Medical Times

THE JOURNAL OF THE AMERICAN MEDICAL PROFESSION

Vol. 66 OCTOBER, 1938 No. 10

PSYCHOPHYSIOLOGY OF THE STOMACH
James J. Stefano

COMPOUND FRACTURES
Julius C. Felicetti

JAUNDICE
John B. Healy

OBSTETRICS IN SOUTHSIDE HOSPITAL
Louis F. Garben

STUTTERING
Frederick L. Patry

OTHER TOPICS

PSYCHOLOGY of the AMERICAN LAXATIVE HABIT . . THE ROLE OF CALCIUM IN ETHNICAL SUCCESS — OR FAILURE . . SURGERY IS SURGERY . . MEDICAL HUMOR (?) IN THE BIBLE . . UNITY OF INTERESTS . . SPECTACLE OF SPECTACLES — AND A DREAM . . THE ENDOCRINE RELATIONS OF CANCER . . NEWS AND NOTES . . CONTEMPORARY PROGRESS . . MEDICAL BOOK NEWS . . CORRESPONDENCE

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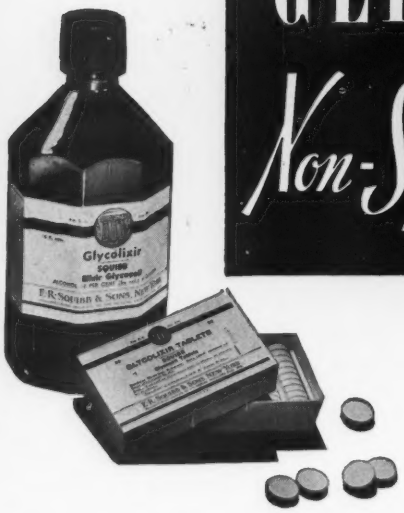

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[1] Wilder, R. M.: General Discussion: *Proc. Staff Meet.*, Mayo Clinic 9:606 (Oct. 3), 1934.

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MEDICAL TIMES. Established 1872 and published monthly by Romaine Pierson Publishers, Inc., East Stroudsburg, Pa., and executive and editorial offices at 95 Nassau St., New York, N. Y. Entered May 24, 1933, as second-class matter at the Post Office at East Stroudsburg, Pa., under the Act of March 3rd, 1879. Subscription price $2.00 a year.

Editorials

ESTABLISHED IN 1872

Psychology of the American Laxative Habit

THE functions of nutrition and sexuality are closely interrelated. This goes back to the fact that the infant makes the output of his alimentary tract, as well as its intake, a means of pleasure. Jones (*Papers on Psychoanalysis*, Ch. XL, pp. 664-688) has elaborated this defecatory theme exhaustively. Normally, this means of pleasure is repressed early in life, but a strong ambition to achieve control of the sphincters is a basic trait. Then the feces are something that the infant *makes*, which gives this gift to the world value, and there is a pride in the achievement, for which his mother praises him—the first manifestation in man of self-expression, indeed, of the creative impulse. There is also an early aim to increase sphincteric control, which might at times, of course, take the form of expediting excretion. All this interest is infantile but it may revive in the adult, particularly when a veritable propaganda, having directly to do with defecation, is aimed at him by commercialists.

This analerotic character, so much emphasized by the Freudian school, and so often grossly apparent in the relatively infantile orders of mankind, gives us the prevailing cult of the privy and the vast coproctic folklore so often disguised as humor. This preoccupation with the water closet and keen interest in the events of the toilet found perfect expression a few years ago in the shape of Chic Sale's choice book of fecal episodes in the life of Americans.

What wonder, then, that the laxative promoters find an audience perfectly conditioned for their suggestions and appeals. This propaganda fits in exactly with the national psyche in so far as it is infantile.

A very practical aspect of the question has to do with the incidence of appendicitis, undoubtedly a related consequence, many times, of dosage with laxatives and cathartics. So, too, do colonic ailments figure in the vicious set-up, constituting a physiological exploitation of the "feces market."

There is singular truth in the figure of speech about "smelling to heaven" when used in reference to the commercialization of laxatives in America.

The Role of Calcium in Ethnical Success—or Failure

TO the lack of calcium (and phosphorus) in certain soils Dr. Robert Dumont of Brussels ascribes the physical deterioration of the natives of the tropical regions, particularly in the case of Africa and the Philippines. This thesis, founded upon correlative studies of the natives and of soil and vegetable mineralization, has produced a considerable European literature.

Dumont compares interestingly from this angle the natives of the Congo, subsisting upon low-calcium food coming from soil extremely poor in calcium, and showing feebleness, premature senility,

and undue susceptibility to disease, and the Egyptian fellahs, living on a hypermineralized soil, and showing extraordinary resistance to fatigue and infection. The former eat a greater quantity of food; indeed, the fellahs are decidedly frugal in their eating habits. It is in the great difference in the calcium ration that Dumont finds the explanation of this dietetic paradox.

Max Sturm (*Medical Record*, 142:445-446, Nov. 20, 1935) has written a brief but suggestive article in which he gives a theoretical explanation of the etiology of cardiovascular disease. He ascribes a preëminent rôle to calcium deficiency. He believes that such deficiency strikes at the *heart* of nations.

Behind the early migrations of mankind may have been a calcium hunger urge. The fall and rise of nations, in the past, may have been more or less conditioned by this factor.

How can a people lacking calcium be "stout-hearted"? And how can a people lacking stout-heartedness be great?

Surgery is Surgery

IS there really any such thing as minor surgery?

What we mean is obvious enough. Any "solution of continuity" is a potential cause of death. A squeezed boil on the nose or upper lip may terminate as a meningitis. A small blister on the foot may initiate an infection of the bloodstream.

One picks up a work on "minor surgery" and notes, among the topics, strangulated hernia, intestinal obstruction, various fractures, etc.

So the subject is muddled. So-called minor conditions are potentially major, and highly so, while some major conditions are actually denominated minor.

We should have wit enough to devise a better terminology.

Strictly speaking, all surgery is of the major order. Yet we all recall how recently tonsillectomy became so classified. The delivery of any obstetric patient, with or without forceps, version or section, is a major procedure. Properly regarded, the removal of a foreign body from the cornea, or of a splinter from the finger, is a major operation. There are great risks.

There is no minor surgery.

The Journal of the American Medical Association had this to say the other day on the subject:

> In two recent communications, Hubert A. Royster makes a plea that the term "minor surgery" be eliminated from our nomenclature because of possible implications. He advances the argument that the labeling of certain procedures as minor may mislead an intern or a general practitioner into believing that any condition requiring surgical intervention can be regarded as minor. Only one of 104 surgeons whom he consulted believed the division of surgery into major or minor is justified. The principal objection to the term, it appears, is that it is vague and ill defined. There exist no definite criteria by which to designate any one procedure as minor or major. What appears to be a simple procedure may develop into the most complicated one. What is a minor operation in the hands of a skilful surgeon may prove a major one in the hands of the unskilled surgeon. Such criteria as time required to perform an operation, the mortality, the skill required, the question of anesthesia, the question of whether it can be performed in the office or requires hospitalization are all variables. The suggested substitutes for the term minor surgery, such as office surgery, ambulant surgery or dispensary surgery, are hardly an improvement. Royster argues that all surgery is based on the same fundamental principles and is therefore not divisible. In no other field of medicine does a similar division into major and minor procedures exist. Actually the term minor surgery has largely disappeared from the curriculums of our leading medical schools.

Medical Humor (?) In the Bible

WHETHER the following selection from II. *Chronicles*, xvi, is to be taken as intentional or unintentional humor, we leave to the discernment of our readers:

> And Asa in the thirty and ninth year of his reign was diseased in his feet, until his disease was exceeding great; yet in his disease he sought not to the Lord, but to the physicians. And Asa slept with his fathers.

Apart from the question of humor, this passage suggests arteriosclerotic disease and senile gangrene, for Asa appears to have been about eighty-three years of age at the time of his death. In those ancient days, as now, lesions of the feet would seem to have been a very serious problem at times. Had Asa been much younger at the time of his death, the evidence for diabetes or for thrombo-angiitis obliterans in the world of a thousand years before Christ would have been fairly good.

However, there would seem to be very good evidence in the passage quoted for the antiquity of physicians, that is, of a

class of practitioners who treated diseases from a non-religious point of view. We had supposed that all the physicians in those days were priests, but Asa "sought not to the Lord." The priestly physician must have had competitors, professional pregenitors of the doctors of today.

✚

Unity of Interests

THE man who ignores ethical amenities is sure to be one who ignores the general interests and fails to uphold the solidarity of the profession. In matters involving ethical considerations he ignores his "colleagues" unless perchance they are personally known to him and linked to him in some way. "Strangers" get short shrift. If all were like unto him there would be no professional solidarity at all. How sincere can the interest of such men be in the large social and economic problems now affecting their professional "brethren?" They cannot see that "not giving a damn" brings about peril to all, including themselves. Not even on a purely materialistic basis are they aware of their own interests. When it comes to higher considerations they are revealed as spiritual imbeciles.

The fate of the profession depends on its moral strength, after all.

Spectacle of Spectacles—and a Dream

ORGANIZED medicine is itself responsible for the protection of the public against *medical* quacks and charlatans. Through improved educational methods in the medical schools and pressure upon legislatures a high order of service has been developed, with qualifying examinations before practice is entered upon, and provision for postgraduate study.

It would be a desirable thing if our statesmen were to take comparable steps to insure protection of the public against *political* quacks and charlatans. Those seeking the suffrages of the people for public office should be qualified and licensed.

It's just about as necessary in the one case as in the other. Look at the present status of government.

A myriad of men really unfit to fill the lowest jobs in their communities are holding high office all over the land. This is not democracy; it is a ruinous racket.

The havoc of which poisonous political quacks are capable constitutes an even greater menace to the citizenry than that threatened by medical charlatans. Economic and social death is dispensed by the former as well as literal death, for example, through war mongering.

Reform wouldn't be any harder for the statesmen than for the doctors; the job couldn't be any harder than that done by the doctors.

NEPHROPTOSIS

Perusal of medical literature of the past five years discloses an ever increasing interest and revival of the neglected, discarded and ridiculed disease that swept medical circles in the early twentieth century: nephroptosis or mobile kidney. This entity is sustaining a new lease of life, and rightly so, because of several facts which were at one time thought pure theories, but are today established as basic and fundamental.

Similar to other cycles and fads in the practice of our healing art, this disease was abused and, like chronic appendicitis, acidosis, auto-intoxication, and other medical "hobbies" was ridden to an abused and ignoble death. But time, our better identity of pathology, the progress of elimination of disease by more careful investigation, and the development of more accurate means of diagnosis, has created a saner perspective regarding the chronic complainer, and various diseases, like Lazarus, resurrected from the dead, is this one of nephroptosis.—G. E. SLOTKIN, M.D. In *Urologic and Cutaneous Review*, May, 1938.

A SUMMARY OF THE *Function of The Stomach* FROM A PSYCHOPHYSIOLOGIC STANDPOINT

JAMES J. STEFANO, M.D.
Brooklyn, N. Y.

1. In all people the stomach is a temporary storehouse for food ingested. In it physical and chemical changes, due to many factors, occur before its contents are passed on.

2. In some people, the stomach has the added function of acting as a barometer for pathological processes in other parts of the body. Toxic stimuli cause changes in the delicate balance of the sympathetic and parasympathetic systems. The changes are probably due to the affect of toxins on the diencephalon, with a resulting vagotonic irritability.

3. In some other people, the stomach has the added function of acting as a safety-valve for their emotional expenditure, thereby serving as a mirror of their minds. This phenomenon is manifested by hyperactivity of all its functions, varying in accordance to the type and character of the stimuli. The secretions are simultaneously and similarly affected. The circulation is also influenced. Prolonged emotional stimulation can cause a cessation of all gastric functions because of gastric muscle fatigue.

THE increased stomach activity which occurs as part of the emotional reactions these people experience takes place at the expense of the energy the stomach musculature needs for vital functions. Oftentimes, as a result, the energy required for digestion is so greatly consumed for emotional expenditure that it falls below the level of "safety" for proper normal functions. As is often seen clinically, food eaten during this period of stomach overactivity is not properly digested. Food consumed in these circumstances acts as an irritant and as such the stomach attempts to rid itself of its contents. The symptoms which are manifested because of the stomach's efforts are what we now interpret as indigestion. Of course the complaint will vary according to the type of food eaten and the amount of energy left in the stomach muscles after these emotional stimuli have been expended. So that one can see that the complaint in this type of individual does not represent an index of the pathological changes in the stomach but measures the intensity and character of the emotional reaction. Very often the disturbance in the stomach activity represents an unpleasant experience of a psychic nature which is being reproduced in this bizarre fashion, and it symbolizes a deep-seated inability to face reality in the patient's present set-up.

Rationalizing further from a psychobiological approach, it represents the response of such patients to life's happenings. In view of the fact that the instinct to live can only be maintained by food, we have interpreted the emotional effect on the stomach with its consequent disturbance of digestion as psychic death because of the interference partially or completely with the preservation instinct.

As a result of the changes that become necessary when the cause and effect of the emotional reaction is considered, a definite retrogression of personality occurs from the age level attained to that of an infant. The mannerisms of these patients are distinctly infantile and their behavior is very well expressed by the following observations:

1. They are willing to assume a dependent attitude.

2. They become very much interested in themselves.

3. They assume phantasy thinking which oftentimes results in mental confusion, foolish ideas, and at times phobias.

These are most likely due to the fact that although a child grows up, it never completely releases itself from the ideas cherished in childhood in relation to its mother and father. The result of it all is a recurrence of the struggle between incest desire and cultural prohibition.

ALSO, a great majority of these patients have sexual disturbances. This is due to the fact that sexuality in infants is not genital, and the areas of erotism may be variable. However, when one recollects that the sex urge is one of the strongest influences of life, and is dependent upon sex hormones and hormonal attractions, it therefore becomes physiological. As the biological status of these patients remains the same, and the sex urge continues but is unable to have physical expression because of the personality changes, a conversion of these stimuli occurs through the autonomic nervous system to be expended by way of the stomach branches of the parasympathetics. We are of the belief that if this safety-valve were not available a psychosis would occur. Therefore, it is fair to assume that complex gastric disturbances manifested by epigastric discomfort, belching, nausea, vomiting, irritability, nervousness and collapse may be easily interpreted as a psychic masturbatory reaction whose purpose is to expend the accumulated sex stimuli through the autonomic nervous system. This hypothesis may very well be explained by the similarity of a graphic study of the physical side of sex and the complex gastric syndrome referred to above.

These patients when changing their total personality assume their original status of introversion. The over-compensation that they have developed since early adult life is thrown to the wind as the need for personality changes occurs for biological preservation. The physiology so described may thus be called a compromise reaction to meet the vicissitudes of life. In so doing they are able to retreat from the bitter responsibilities of life and assume the rôle of a protected infant again.

THE LUCID INTERVAL AND ACUTE APPENDICITIS

Partial or complete gangrene of the appendix is frequently associated with a subsidence of symptoms and absence of physical signs—the so-called "lucid interval." This is confused with the resolution following an acute involvement of the appendix of less virulent character. The subsidence of symptoms and signs accompanying both is due to diminished intra-appendiceal pressure: the relaxation incident to devitalization of the serosa in the first instance, the absorption of the products of inflammation in the latter.—J. O. BOWER, M.D. In *American Journal of the Medical Sciences*, April, 1938.

SURGICAL ASPECTS OF GONORRHEA IN THE MALE

In the female, the surgical aspects of gonorrhea command considerable attention because of the serious pathologic consequences which follow gonorrheal infection in the female pelvis. In the male, however, while the complications which require surgical interference are greater in number they are far less serious in character and do not constitute a menace to life, as they do in the female. For this reason, perhaps, they are not so widely recognized. Nevertheless, they are productive of much distress and physical incapacity in the acute. — A. L. WOLBARST, M.D. In *Urologic and Cutaneous Review*, May, 1938.

COMPOUND *Fractures*

JULIUS C. FELICETTI, M.D.

Hempstead, N. Y.

THIS review includes only cases admitted to Nassau Hospital for treatment from June 1, 1934 to January 1, 1938. In this series the compound fractures of the skull, nose, facial bones, ribs and phalanges were not included.

There were 69 cases in all, and of these there were 48 cases, or 69.6 per cent, in which there were multiple injuries; and 21 cases, or 30.4 per cent, which involved a single fracture.

The age of these patients ranged from 6 to 74 years of age, and the average was 34 years old. There were 74 per cent males and 26 per cent females.

The causes of these injuries were varied and the distribution was as follows: 40 cases were due to automobiles; 5 cases were due to aeroplanes; four cases occurred in the home; 8 cases occurred in the street; 3 were due to motorcycles and 9 miscellaneous cases occurred in sports of various types.

The hospitalization of these patients ranged from 1 day to 130 days, the average stay being 22 days.

These patients were treated as soon as possible after admission to the hospital. We find that the time elapsed from admission to the time of operation varied from 15 minutes to 3 hours, depending on the case, the average time elapsed being 1 hour and 30 minutes.

The type of anesthesia used varied with the type of case and we found that 16 per cent received local, usually 2 per cent novocain preceded by an H.M.C. The remaining 84 per cent of the cases received general anesthesia of gas-oxygen, ether or ethylene, or a mixture of these agents.

The time taken for operation in these cases was 12 minutes for the shortest to 2 hours for the longest; the average time of operation was 50 minutes.

The bones involved in this group of cases were the radius, ulna, humerus, metatarsals, metacarpals, femur, tibia, fibula, patella, clavicle, pelvis, vertebra, tarsal and carpal bones. Of the 48 cases which were multiple one or two bones sustained compound fractures, but usually there was a simple fracture associated with them.

THERE were 5 deaths in this series, giving us a death rate of 7 per cent. Of those that expired, we found that they were in profound shock and usually had fractured skulls or crushing injuries of the pelvis. The shock was treated immediately and observed for about one hour to see if there was any improvement. If there was some sign of improvement they would be treated in the usual way. I will give a brief summary of these deaths to show the type of case with which we are dealing. The first was a male 74 years of age who was struck by an automobile. On admission he was in coma and severe shock. He had a compound fracture of the right tibia and fibula, fracture of the right humerus, dislocation of the right elbow, and a fracture of the left tibia into the knee joint. This patient expired 2 hours after admission. The second case was a female, 34 years of age, who was struck by an automobile and was admitted in severe shock. She had compound comminuted fractures of the right and left tibia and fibula. She was treated for shock and under local anesthesia a traumatic amputation of the left leg below the knee was done, and débridement and reduction with plaster of the right leg. She did not react and expired 7 hours after admission. The third case was a male, 54 years of age, also a victim of an automobile accident, who sustained a fractured pelvis with a disarticulation of the left sacro-iliac joint, together with compound fractures of the right tibia and fibula. Under local anesthesia débridement of the right leg, reduction and

plaster was done. Scalp and hand and tendon lacerations were also sutured. Traction was applied to the left lower extremity. The patient expired 2 days later. The fourth case was an 18-year-old male who met with an aeroplane accident and sustained a fractured skull, compound fractures of the right tibia and fibula, fracture of the femur and pulmonary collapse. Under local anesthesia débridement was done and a Steinmann pin placed through the os calcis and traction applied. He was treated for shock and given oxygen but expired 4 days after admission. The fifth case was a 31-year-old male who was crushed by a large rock in an excavation. He sustained a compound fracture of the pelvis, posterior displacement of the left sacro-iliac joint, extensive lacerations of the perineum and a rupture of the urethra. Under ethylene-ether anesthesia a perineal section was done, traction and manipulation of the left side of the pelvis applied, with a Bradford frame and traction to the left lower extremity. He was given the therapeutic dose of gas bacillus and tetanus serum and a transfusion on the 5th day, but the patient developed thrombophlebitis of the left leg and gas bacillus infection of the thigh and expired 8 days after admission.

There were 9 cases, or 13 per cent, which became infected, resulting in osteomyelitis and subsequent ankylosis of the joint involved. These cases, together with the 5 deaths and 3 non-union instances not as yet mentioned, are included in our poor results. The results were classified as:

GOOD: If 50 to 100 per cent of the fractured surfaces were in contact.

FAIR: If ⅓ to ½ of the fractured surfaces were in contact.

POOR: If ⅓ or less of the fractured surfaces were in contact; also infections with resulting ankylosis or non-union; deaths or gross deformities such as bowing, angulation and shortening were included. No case was left alone if less than ⅓ apposition was obtained, and shortening or angulation.

From the above classification our results were as follows in this series:

GOOD: 45 cases or 65 per cent

FAIR: 9 cases or 13 per cent

POOR: 17 cases or 22.3 per cent

If we subtract the 5 deaths from our poor results our percentage is about 17 per cent.

ALL these compound fractures were treated with essentially the same objectives, that is: 1) to immediately change the contaminated wound into a clean wound; 2) to control any hemorrhage; 3) to reduce and adequately immobilize the fragments.

We regard compound fractures as acute emergencies and treat them as such, similar to acute appendicitis. On admission the patient is examined carefully so that the fractures are not disturbed unnecessarily, thus increasing the shock further. If we find the patient in severe shock we do not disturb the fractures but treat the shock with saline-glucose infusion, caffeine, adrenalin and oxygen-CO_2 if needed, and external heat. When they have reacted sufficiently we then proceed with the operation, and sometimes the infusion is continued through the operation. The patients who are not in severe shock, but complain of acute pain, are given an H.M.C. as a preoperative medication. During this interval, while the operating room is being prepared, the patients are given therapeutic dose of tetanus and gas bacillus serum.

The type of anesthesia to be used is now determined. If the patient has a severe skull, face or chest injury a general anesthesia is contra-indicated and we are forced to work with a local anesthesia. We prefer a general anesthesia to a local because we feel we can do a more thorough débridement. If the wound is a small puncture wound, we open it wide and treat it the same way as a wide open macerated wound.

The Operation:

WITH the patient under anesthesia, the wound is protected with sterile gauze; and the skin around the wound, and well above and below, is shaved. Then it is scrubbed thoroughly with gen-

erous quantities of soap and sterile water. Finally it is washed with alcohol and ether. The wound is cleansed in a similar manner. We then proceed with the débridement of the wound. The skin edges of the wound are cut away, leaving clean-cut healthy skin edges. Then any subcutaneous fat or fascia which is loose and devitalized is removed. The muscles which are macerated and devitalized are excised and finally any contaminated bone fragments and loose small bone fragments are removed; the wound is constantly irrigated with sterile water during the operation. The wound and all pockets are inspected and again irrigated to wash out any foreign material or small fragments of tissue. The wound is left wide open and packed with vaseline gauze; occasionally we place one or two sutures in the skin edges to prevent further retraction. The fracture is then reduced and if the reduction can be maintained easily we apply a well moulded circular plaster, well above and below the bone involved, usually including the joints above and below the fracture site. When we have difficulty in maintaining our reduction we either use internal fixation or external methods of fixation. In external fixation we use either Kirschner wire or Steinmann pins through the bone above and below the fracture site and then maintain the reduction by incorporating the pins or wires in the plaster. Occasionally we use the traction distraction apparatus to effect a reduction. When we maintain our reduction by internal fixation we either use a piece of beef bone in the medullary canal or a piece of loose fragment of bone which can be cut to fit into the fractured ends. Occasionally we use Kirschner wire or Steinmann pins through the cortex and into the medullary canal, and the other end of the pins protrudes from the skin. Then the plaster is moulded about the pins to maintain the reduction. A window is cut through the case over the wound.

We have observed that the general condition in many of the cases which were in severe or moderate shock was markedly improved after the fractures were reduced and adequately immobilized.

After Care:

X-RAYS were usually taken the following day. If they were satisfactory the patient was not disturbed. If the reduction was not satisfactory the plaster was cut or wedged and the necessary manipulation was done to effect a satisfactory reduction. These cases we kept in bed with the part elevated on pillows and the circulation and temperature were observed. If the swelling and circulation and temperature remained satisfactory the wounds were not dressed or disturbed for 10 to 14 days. At this time the cast was changed and the wound dressed, and under local a secondary closure was done. If there was great loss of skin and the skin edges could not be approximated without great tension, "pinch" skin grafting of the wound was done and a new moulded circular cast was applied. If there were rise of temperature and disturbance of circulation the wound was opened and dressed. The wound was examined and if pocketing was observed it was drained and the wound was dressed until the temperature remained normal. The cases which had pins or wires in them were observed for signs of infection or loosening and, if such signs were found to be present, they were removed. If there was no reaction about the pins they were removed by the end of the third week.

All patients were discharged from the hospital as soon as they could be cared for at home and office. The casts were changed as often as was necessary to maintain adequate immobilization. No case was discharged unless there was clinical and definite x-ray union.

IN this series there were three cases which were considered to show nonunion or delayed union. ***The First*** was a 21-year-old male who was in an automobile accident and sustained a compound fracture of the left humerus. It was a transverse fracture in the middle of the shaft. Débridement was done under general anesthesia, a wire placed through the olecranon for traction and reduction, and a plaster spica applied incorporating the wire. After 14 days in the hospital with temperature normal

the plaster was changed and a secondary suturing of the wound was done and the wire was removed. The position of the fragments was maintained end to end and he was immobilized for 30 weeks. At the end of this time there was fibrous union and no x-ray union. The patient then left the county and was not seen again.

The Second case was a 45-year-old male who was injured by a gunshot and sustained compound fractures of the left tibia and fibula at the junction of the lower and middle thirds. Under general anesthesia débridement was done and reduction was maintained by a pin in the upper and lower fragments. Some angulation was noted and corrected the next day. After 18 days the wound was closed and the pins removed. There was noted a low grade infection in the upper pin. The patient was last seen 6 weeks after the injury and there was no evidence of clinical union. *The Third* case was a 21-year-old male who was in an automobile accident and sustained a compound fracture of the right femur, comminuted fractures of the right tibia and fibula, a fractured skull and laceration of the forearm. A débridement was done under local, a Steinmann pin placed in the os calcis, a plaster boot was applied to the leg, and the femur was put up in traction. Blood transfusion was given the next day. After 4 weeks his temperature remained normal and the wound was granulating. Skin grafting was then done and at the end of two weeks the wound was covered and a plaster spica was applied. At the end of 16 weeks there was no evidence of bone union in the tibia and fibula.

Conclusion:

A REVIEW of 69 cases of compound fractures is presented. Immediate and early treatment should be instituted to obtain satisfactory reduction, to prevent further shock, and to decrease the incidence of infection.

Compound fractures should be adequately immobilized immediately with plaster when possible and they should be immobilized until there is both clinical and x-ray union.

The wounds should never be closed after débridement. It is advisable to wait about 10 to 14 days to be certain that no infection is present, and then proceed with secondary suturing and skin grafting if necessary.

All non-immobilized joints should be kept in active motion to prevent prolonged disability after the period of fracture immobilization.

PROFESSIONAL BUILDING.

THE PRE-EMERGENCY PROSTATIC

"Now, I don't want any operation," says our Prominent Business Man, on his first visit. The laity has the opinion that men past middle life who have difficulty in voiding (and what man at this time of life does not have such symptoms at times or chronically), are of interest to their regular doctors only in a surgical aspect . . .

Is the lay prejudice well founded? Are we shirking our responsibility of individual study in the early decades of this progressive syndrome called "prostatism," and of guiding patients to the maximum health and longevity through such studies? Would they then avoid, or postpone for happy years, the common break-downs, cardio-vascular, renal or septic? Are we ignoring the earlier stages in this decade of patients until they become "the surgical emergencies" of the following decade? — WALTER PRITCHARD, M.D. In *Urologic and Cutaneous Review*, July, 1938.

HYPERTENSION

Hypertension, when it becomes a threat, through the strain it imposes upon the heart and the blood vessels, exhibits not only an elevation of the systolic but also a distinct increase in the diastolic pressure.—H. O. MOSENTHAL, M.D. In *Bulletin of The New York Academy of Medicine*, June, 1938.

Associated Physicians
OF LONG ISLAND

SCIENTIFIC
PROCEEDINGS

Jaundice

JOHN B. HEALY, M.D.

Babylon, N. Y.

Introduction

THE liver is the largest organ in the body. It amounts to about 1/50 of the body weight and appears to have greater powers of regeneration than any other functioning tissue. More than eighty per cent of the liver has been removed in animal experimentation without any demonstrable impairment of its function (Bollman). Yet despite these generally accepted facts about liver function and repair and despite its very apparent accessibility for study by way of an external fistula in the dog and duodenal drainage in man we are often baffled in the effort to manage that most common symptom of liver dysfunction, namely, jaundice.

Definition — Limitation—Explanation

IT would be impossible at this time to attempt a discussion of the entire question of jaundice. Because the intrahepatic types are essentially medical rather than surgical problems we will limit our discussion to this phase of the subject from the standpoint both of diagnosis and treatment. When the physician is called upon to decide what mechanism has caused the backflow of bile into the blood and tissues the probability of mechanical obstruction to the common and hepatic bile ducts must be considered as the first cause of the symptoms until proved otherwise.

The lesions commonly mentioned as the causes of this obstruction are only three. Namely: common duct stones, common duct stricture and common duct or pancreatic cancer.

Next the physician must decide if the jaundice is due to a lesion in the hepatic parenchyma and to make these decisions consideration of the pathologic and physiologic mechanism of jaundice is necessary.

Mann in his experiments on hepatectomized dogs has established that bilirubin, the pigment which causes the visible signs of jaundice, is formed from broken-down hemoglobin and that it is brought to the liver for excretion. It has been inferred (Snell) that the site of the transformation of hemoglobin into bilirubin is the reticuloendothelial cells of the bone marrow, spleen, and liver and the excretion of bilirubin is carried on by the polygonal hepatic cells. Therefore on this basis, McNee has evolved a theory of jaundice

Read before the Associated Physicians of Long Island at Great River, N. Y., June 7, 1938.

which fits all forms in the following classifications: obstructive, hemolytic, toxic or infectious.

In the toxic or infectious type there is an injury to the hepatic parenchyma with the result that normally formed bilirubin may fail of excretion or else that which has passed the polygonal cells of the liver may be reabsorbed.

The injury to the hepatic parenchyma may be in the form of functional derangement, degeneration, atrophy or inflammatory change; these changes are manifested in the pathologic picture either by simple cloudy swelling or actual necrosis of hepatic cells as seen in acute and subacute yellow atrophy. Again, the generalized destruction and disorganization of hepatic parenchyma as found in chronic passive congestion and cirrhosis are sufficient in themselves to produce jaundice. Finally, the destructive lesions of infection and back pressure which remain after the obstructive conditions in the larger bile passage have been removed must be included. In the more severe cases which end fatally the liver is a mixed picture of inflammatory and degenerative change with evidence of reparative process even to the extent of nodular hyperplasia.

From observation of these changes and in support of the diverse views of the French and German schools, McNee believes that the retention of bile pigments is the result of *changes* in the *hepatic cells* and *cholangeitis* of the *finer bile passages.*

From these observations it is apparent that the essential changes in intrahepatic jaundice are quite the same no matter what the causative agent may be. One may encounter any of these four conditions: healing, chronic progressive hepatitis, toxic cirrhosis or atrophy.

It seems obvious from the above description that to attempt a pathological classification of intrahepatic jaundice would be quite confusing and equally so would be a clinical one because of the many "borderline" cases. An etiological classification as follows simplifies matters because it conveys the idea of the toxic factors which are known to produce intrahepatic jaundice.

1st. Infectious or toxic jaundice (epidemic jaundice, campaign jaundice); 2nd. spirochetal jaundice; 3rd. toxic jaundice due to drugs, cinchophen, arsenic, mushrooms and alcohol; 4th. toxic jaundice from systemic disease such as exophthalmic goiter or toxemia of pregnancy. In addition to these we have the jaundice of portal cirrhosis and that due to the secondary changes in the parenchyma produced by previous biliary obstruction.

THE catarrhal or epidemic forms of jaundice are readily diagnosed and treated. In certain cases such an apparently mild infection may go on to a considerably more serious condition with ascites and no sign of improvement in the jaundice for weeks or months, ultimately ending, however, in a favorable outcome.

The widespread custom of administering antirheumatic remedies containing cinchophen and the numerous reports of high mortality rates in those cases developing toxic hepatitis have justified the name "cinchophen jaundice." Many persons use cinchophen for years without any apparent harm to themselves; in fact, it is estimated that the user stands a chance of 1-500,000 of developing toxic hepatitis. It is believed that a definite idiosyncrasy to this drug exists in most cases. The pathologic changes in this condition are those of an acute or subacute yellow atrophy.

It might be well in passing to mention the necessity of considering arsenic as a possible cause of toxic injury to the liver, as are the toxemia of pregnancy, certain forms of sepsis, and exophthalmic goiter.

The degenerative hepatic lesions which may follow complete mechanical biliary obstructions are of interest both to the surgeon and to the internist. In long-standing cases of this kind secondary biliary cirrhosis intervenes and cases have been reported in which there has been almost complete destruction of the hepatic parenchyma. The obvious indication in these cases is the detection and the removal of the etiologic agent and if there is any doubt the proverbial look by the surgeon is always justified.

Function Tests—Liver

IN an attempt to evaluate the various methods of testing liver function in the presence of jaundice our laboratory

depends largely on the van den Bergh, the icterus index and the bromsulfalein test. We start out with the assumption that the question to be determined is whether we are dealing with a blood dyscrasia (hemolytic jaundice), a lesion of the hepatic parenchyma (hepatogenous jaundice), or an obstruction to the flow of bile in the larger bile passages (obstructive jaundice). Just as in determining changes in the functional capacity of the kidneys we depend largely on the estimation of nonprotein nitrogen and blood urea so, too, in determining the value for serum bilirubin, we gain useful information of the functional capacity of the liver. Bilirubin exists ordinarily in the blood serum to the amount .1 to 2 mg. per hundred cubic centimeters and it gives an indirect reaction to the van den Bergh test. In the hemolytic jaundice of blood dyscrasia the excess of bilirubin is bound in the blood stream and is not eliminated by the kidneys. It gives an indirect reaction and the amount rarely exceeds more than 6-7 mg. per hundred cubic centimeters of serum. It is believed that when the indirect reacting bilirubin reaches a level or more than 4 mg. per hundred cubic centimeters of serum there is likely to be a functional disturbance in the cells of the liver.

The conditions in which indirect reactive serums are found are as follows: pernicious anemia, familial—hemolytic jaundice, acute hemolytic anemia, sickle-cell anemia, paroxysmal hemoglobinemia, transfusions of the wrong type of blood, phenylhydrazine poisoning, cardiac decompensation, hemolytic septicemia, malaria, blackwater fever, lobar pneumonia and icterus neonatorum.

The characteristic features in this type of jaundice are its lightness, the acholuria and the indirect reacting low percentage of bilirubin as estimated by the van den Bergh test.

In the hepatogenous and obstructive forms of jaundice the direct reacting bilirubin is usually found in much higher concentrations. In some acute forms of hepatic jaundice along with the obstructive types due to neoplasm the values for serum bilirubin may run as high as 30-50 mg. per hundred cubic centimeters. In mild parenchymal lesions and in the intermittent or partially obstructive types the values may vary from 10 to 30 mg. per hundred cubic centimeters; while in the subsiding acute intrahepatic cases and in the various forms of portal cirrhosis, of syphilitic hepatitis, of stone in the common bile duct and in the infectious form of cholecystitis the lower grades of bilirubinemia of from 2 to 10 mg. per hundred cubic centimeters of a direct reacting van den Bergh may be found.

The Icterus Index

THIS test to determine the extent of the bilirubinemia is not quite so accurate, but it is simpler in execution and may serve a very useful purpose. If repeated frequently and plotted as a curve the results often are of diagnostic and prognostic importance. In acute intrahepatic forms there is a rapid rise which is followed by an equally rapid fall.

In chronic parenchymatous forms the curve is low and irregular while cases of rapid degeneration of the liver tissue show increasingly sustained rises. Falling curves as a rule mean returning patency of the biliary ducts or a regenerating liver, while rising values signify a complete obstruction or a rapidly degenerating liver parenchyma.

The Bromsulfalein Test

THIS very satisfactory test of liver function is easily done. Five mg. of the dye per kilogram of body weight is injected intravenously and one hour later 5 c.c. of blood is withdrawn from the other arm and the serum compared with standard tubes in a colorimeter. The grading of the degree of impairment of liver functions is made on the amount of dye retained. Cases of a mild degree of retention (from 4 to 12 per cent) are significant, because in early cases of parenchymal injury or moderate obstruction there may be no evidence of clinical jaundice. The test is of particular importance in those patients with a low (2-5 mg.) or normal value for bilirubin and who are not jaundiced. Positive tests are found in cirrhosis, Banti's disease, chronic passive congestion, Pick's disease, fatty degenera-

tion of the liver, amyloidosis, syphilitic cirrhosis and in the recovery state of hepatogenous jaundice. It is of diagnostic value in determining early metastatic malignant liver involvement secondary to abdominal and rectal conditions. It may be used to determine the reasonable safety of surgical procedures before evidence of clinical hepatic damage is discernible. The toxic states of exophthalmic goiter will show a positive bromsulfalein test.

Treatment

I HAVE mentioned before that the destructive and degenerative changes that take place in the liver parenchyma as a result of injury proceed in about the same manner no matter what the causative agent may be. Likewise the problem of protecting the liver parenchyma is somewhat the same in all types of hepatic injury. However, there are certain general factors which impede and prevent the normal processes of regeneration and repair, namely, the presence of a complete obstruction of the bile ducts; or in the event that a hepatotoxic agent such as cinchophen is still operating; or if there is a well marked reduction in the flow of portal blood. The first two conditions may in some cases be corrected while the third in the course of time may be relieved by compensatory changes in the circulation.

Dietary

A DIETARY regimen with a high carbohydrate content is the usual practice in all forms of liver disease. A diet of 350 or more gms. of carbohydrate with 1 to 1.5 gm. of protein per kilogram of body weight and a sufficient amount of fat to meet the caloric requirements is suggested. If the condition of the patient prevents the adequate intake of carbohydrates by mouth the lack should be overcome by the administration of glucose by vein.

A great deal has been said about the intravenous use of glucose in hepatic insufficiency and its value in this condition is indisputable. From 1 to 3 liters of a 5 to 10 per cent solution should be given daily. This should be in saline solution if the plasma chlorides are low. Suprarenal cortical hormone has been used by Snell to help maintain the concentration of chlorides in the blood. Oxygen and small blood transfusions are very often important aids in the treatment of these cases.

Treatment of Ascites and Edema

ATTEMPTS to elevate the concentration of the plasma proteins, thereby increasing the colloidal osmotic pressure of the serum, are to be striven for in the management of this distressing condition. The use of a 6 per cent solution of acacia on three consecutive days is strongly recommended. In addition to the above measure large doses of all available concentrated forms of vitamins have been used. Intramuscular injection of liver extract may be of benefit because of its direct effect on nitrogen balance and on the retention of protein.

Mention of diuretics has been reserved for the last because it is believed that this method of treatment should be used only when there is a favorable response to one or two injections and, if this fails, tapping, which entails far less risk, may be resorted to frequently without greatly affecting the general condition of the patient.

Anemia

THE macrocytic anemia of liver disease is treated with large doses of liver extract, iron and small transfusions.

Bleeding

RECENTLY Quick has noted the importance of prothrombin deficiencies in "cholemic" bleeding. Further information has revealed the necessity of the presence of bile in the bowel for the maintenance of a normal level of prothrombin and of late considerable importance has been attributed to a lack of a new substance found by Dam in hog-liver fat and alfalfa called vitamin K, the coagulation vitamin.

Summary

THE importance of three tests of liver function has been emphasized, namely,

the van den Bergh, icterus index and the bromsulfalein.

The necessity of maintaining optimal conditions for regeneration and repair is the chief indication in the treatment of parenchymatous liver disease. High carbohydrate diet, vitamin concentration and liver extracts are suggested. Adequate fluid intake, glucose, transfusion, acacia and vitamin K are mentioned.

163 FIRE ISLAND AVENUE.

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Obstetric Cases

IN SOUTHSIDE HOSPITAL BAY SHORE, NEW YORK

LOUIS F. GARBEN, M.D.
Islip, N. Y.

THIS paper is a rather rapid, sketchy review and analysis of the obstetrical cases encountered at the Southside Hospital in Bay Shore from the opening of the hospital in 1923 until May 1 of this year. In order properly to evaluate our results, we should consider the following facts:

1—That from 1923 until 1930, the maternity cases were all delivered in a delivery room which was an integral part of the general hospital; and were then returned to beds in the same ward or in adjoining rooms with general medical and surgical cases.

2—Since early in 1930, all cases have been delivered in the new maternity wing, which is a separate unit.

3—There are forty or more doctors on our hospital staff and 90 per cent of them do their own obstetrics; so that this report really reflects the results of their efforts. All of these men are doing general practice and none specializes in obstetrics. However, there are a few men who have taken extra study in this line and who, although doing general practice, give special attention to obstetrics. These men are in charge of or associated with the obstetric service at the hospital.

General supervision of the department is in the hands of the chief attending obstetrican, who, like the others, is a general practitioner giving special attention to obstetrics in his practice.

Cases, 1925

#1874 E. S. age 32. Para 2. Dr. G.

Previous pregnancies normal. No prenatal care though vomiting since early pregnancy.

Hospitalized at seventh month. Emaciated, semi-comatose.

Treatment — Glucose, saline clysis, labor induced with catheter, no improvement. Stillborn child; low forceps; death in coma.

Cause—Toxemia of pregnancy, acute yellow atrophy, nephritis.

Comment—No consultation.

#1328 D. Y., age 28. Para 2. Dr. M.

Labor at term. Admitted with a diagnosis of lobar pneumonia on 3-10-25; died on 3-15-25.

Treatment—Digitalis, mustard plaster, codeine, whiskey, camphor, oxygen, delivered with chloroform anesthesia.

Comment—1. No consultation. 2. No laboratory work. 3. No transfusion.

Read before the Associated Physicians of Long Island at Great River, N. Y., June 7, 1938.

1926

#3186 Para 1, age 23. Dr. McC.

High forceps, difficult delivery, sudden death four and one-half hours after delivery.

Diagnosis — Pulmonary embolism. Bleeding moderate.

Cause—Embolism.

Comment—No consultation. No cesarean.

1927

#3857 C. M. Gravida 3. Para 1, age 37. Dr. H.

Two previous miscarriages.

Admitted on 5-14-27. Severe hemorrhage at home before admission.

Diagnosis—Premature separation of placenta with low implantation.

Delivery was accomplished by rupturing the membranes, followed by version and extraction; considerable bleeding during the process. One hour after delivery, the patient went into shock and failed to react.

Treatment—Clysis. No transfusion was done.

Cause of death—Hemorrhage; premature separation of placenta.

#4445. J. W., age 39. Para 3. Dr. H.

Admitted 9-11-27. Vomited throughout pregnancy. Headache frequent and severe. Gush of blood from vagina in August; no recurrence. Pyelitis on admission.

Labor fourteen hours—normal. One vaginal examination; urological consultation.

Diagnosis and cause of death—Puerperal sepsis; pyelitis.

#4517. S. S., age 37. Para 8. Dr. T.

Admitted 9-29-27. Due Oct. 1st. Bleeding began 9-17; in a New York Hospital for one week and then went home.

On 9-29 sudden profuse gush of blood at home; arrived at Southside Hospital exsanguinated and died one hour after admission. Treated for shock.

Cause of death—Hemorrhage; placenta praevia.

1928

#5100. S. S. Colored. Para 2. Dr. H.

Admitted 2-27-28.

One section previous for twins. Classical cesarean performed; twins delivered.

Operation began at 9:30, ended 12:40. Patient developed sepsis and died on 8th day.

Comment—Three hours for cesarean looks like poor surgery. This surgeon is no longer on our staff.

#4850. Primip., age 23. Dr. G.

Admitted 9-12-28. History of tuberculosis. Normal delivery—low forceps. Normal puerpera until 14th day. Sudden exit.

Diagnosis — Pulmonary embolism; tuberculosis contributory.

#4919. Primip., age 25. Dr. M.

Due Dec. 31st. Admitted 1-8-28. 1. Spontaneous delivery. 2. Chloroform for convulsions. 3. Forced feeding.

Diagnosis—Puerperal insanity. Temperature normal until the 7th day. 105 on the 9th, 10th and 11th day, 103 on the 12th day, 101 on the 13th, 100 on the 14th, 104 on the 15th, 106 on the 16th, 107 at death. Patient quite unmanageable at time of delivery.

1-14—Complained of sore breast.

1-17—Chilly, slight rigidity of body, twitching of eyelids, convulsions—6 convulsions lasting 2-3 minutes. All night much improved, slept.

1-18—Abdominal pain, nervous, holds self rigid, speech incoherent.

1-19—Better.

1-20—Irrational, slept well. In the P.M. talked incessantly, feels fine, irrational, laughing, talking.

1-21—Mental state unchanged, talks, laughs, cries, noisy.

1-23 and 24—Laughing and singing.

1-25—Cyanosed—died.

Neurologist consultant.

Diagnosis—Puerperal mania; exhaustion; acute cardiac dilatation as result of mania; probable streptococcus septicemia.

#6598 Primip. Dr. G.

Admitted 1-8-28.

Normal delivery—no vaginal examination.

Diagnosis—Pyelitis; sepsis.

Treatment—Blood transfusion, consultation, etc.

Died—14th day.

Cause of death—Puerperal sepsis.

Comment—Delivered in old hospital building. No cause found for sepsis.

1929

#6329. L. V. Para 2. 1-4-29. Dr. S.
Patient delivered at home four days previous to admission.
Admitted in convulsions; albumin two plus; sugar one plus.
Treatment—Hot packs, morphine sulphate, colonics, clysis, glucose, phlebotomy.
Patient died in four days.
Diagnosis—Eclampsia (postpartum).

#6493. E. W., age 22. Primip. Dr. Z.
Admitted 2-18-29. Irregular labor pains, three days. One month overdue.
Classical cesarean.
Diagnosis—Puerperal sepsis.
Comment—Why labor three days! Why not low cesarean or hysterectomy!

1930

#9288 G. T., age 32. Para 4. Dr. A.
Previous attempts to deliver at home failed.
Hand, shoulder presentation.
Two vaginal examinations.
Podalic version—breech extraction.
Temperature for seven days; death on eighth.
Treatment—Clysis.
Diagnosis—Puerperal sepsis.

1931

#9550. Primip., age 19. Dr. S.
12-25-30 and 1-2-31.
Twins delivered at home five days previous to admission. Chills on 4th day.
Treatment—Two blood transfusions. Blood acetone negative.
Death 12 days after birth.
Diagnosis—Puerperal sepsis.

#10958. D. B. Primip. Dr. G.
Seven months' pregnancy. Fell down one step. Pain in left groin. Lacerated left broad ligament.
Intraperitoneal hemorrhage.
Operation followed in three days by spontaneous labor and delivery of stillborn child.
Cause of death—Peritonitis following operation; sepsis.

1932

#13100. Age 18. Gravida 2. Para 1. Dr. S.
Chronic endocarditis for 11 years.
Delivered by classical cesarean.
Sudden death 7 days postpartum.
Diagnosis—Embolism; chronic endocarditis.

#11987. C. W., age 22. Primip. Dr. H.
Normal delivery at home.
Five hours later—convulsions.
Died 10 hours after admission.
Diagnosis — Eclampsia — postpartum; acute nephritis.

#11790. N. T. Para 2. Dr. B.
Profuse bleeding, delivered by version.
Bleeding continued.
Died at 1:40, 4½ hours after admission.
Diagnosis—Placenta praevia. Bleeding. Shock.
Comment — No transfusions. No packs.

1933

#13955. E. G., age 18. Gravida 3. Para 2. Dr. E.
Previous history negative except for a large left inguinal hernia present several years.
Spontaneous delivery—no abnormal bleeding; normal in every way until few minutes before death.
Admitted 6-11-33 at 4:40 P.M.
Delivered 6-12-33 at 12:50 A.M. At 9:50 A. M. (6-12), patient complained of gas pain. Hernia out—manipulated.
At 10:00 A.M. patient suddenly became very cyanotic, frothing at mouth.
Died at 10:10 A.M.
Diagnosis—Embolism.

#14183. M. S., age 29. Primip. Dr. H.
Admitted 7-20-33.
Died 7-23-33.
Diagnosis—1. Acute nephritis. 2. Chronic endocarditis. 3. Pregnancy 6½ months (died undelivered).
Treatment—BP 210/130. Albumin 4 plus. Glucose, magnesium sulphate, etc.
Cause of death—Nephritis.

#13992. D. P., age 19. Gravida 1. Drs. K,. S., H.
Admitted 6-18-33.
In sanatorium for four months previous for tuberculosis.
6-17—7:00 P.M. Labor pains following enema, after which marked dyspnea but no cyanosis.
Physical — Markedly undernourished white female.

Chest — Tuberculous changes both lungs (active).

6-18—Labor spontaneous — no anesthetic. Stillborn.

6-9—Improved.

6-24—Condition very good, heart normal, chest unchanged.

6-27—Dyspnea.

6-30—Transferred to medical service. Edema of legs, ascites.

Diagnosis—Chronic pulmonary tuberculosis. Pregnancy. Chronic valvular heart disease.

Cause of death—Cardiac decompensation. Tuberculosis. Complication, pregnancy.

#13894 I. T., age 21. Primip. Dr. C.

18 hours' labor. Ether anesthesia. Placenta expelled. Credé (note: small particle retained).

Shock and hysteria.

5½ hours later: shock; no visible external hemorrhage.

Died 10 hours postpartum.

Diagnosis — 1. Hyperthyroidism. 2. Endocarditis. 3. Placenta accreta. 4. Acute anemia.

Comment—Why no transfusion?

Cause of death—Hemorrhage.

1934

#15461. H. S., colored. Gravida 5. Dr. B.

Admitted 4-10-34 at 11:25 P.M. 1. Pregnancy 8 months. 2. Premature separation of placenta.

Delivery—Manual dilation of cervix. Abdominal binder. Forceps. Stillbirth. Placenta lying free in uterine cavity; bleeding continued after expulsion of placenta. Laceration of cervix extending into fornices.

Treatment—Glucose. Saline. Adrenalin (shock). Transfusion.

Died 10:30 A.M.

Comment—Why not cesarean?

Cause of death—Hemorrhage. Premature separation of placenta.

1935

#17644. M. N. Gravida 3. Para 2. age 41. Dr. E.

History—1. Stillbirth seven months. BP 240. 2. 1930 stillbirth—no cause found.

Present history—Last menses Jan. 1935. Three days previous to admission had cerebral hemorrhage.

Admitted 7-2-35.

7-2—Labor induced with bag. Delivered macerated fetus; adherent placenta —manual delivery in two hours. Uterus packed with gauze. Fifteen minutes later "patient must have had another cerebral hemorrhage"; pulse rate changed from 110-120 to 60-64. Breathing became stertorous and patient died two hours later.

BP 250/160.

Diagnosis—Cerebral hemorrhage. Hypertension. Nephritis (toxic). Pregnancy.

1936

No Maternal Deaths.

1937

#22708. M. B., age 35. Para 4. Dr. E.

Premature separation of placenta at term.

Low cesarean—patient in fair shape.

Bleeding continued postpartum and died.

Typed but not transfused.

Diagnosis — Hemorrhage. Premature separation of placenta.

#22266. M. S., age 26. Primip. Dr. B.

Due 8-5. Delivered 8-4.

Delivery—5:25 P.M. Left lateral episiotomy. Low forceps—placenta retained.

7:00 P.M. Patient suddenly went into shock; no uterine bleeding; placenta still retained; complained of numbness in right leg. Pulse rapid, weak. 500 cc. whole blood given.

10:30 Glucose intravenously.

2:00 A.M. Vagina packed.

10:00 A.M. Color better, uterus firm, placenta still retained.

1:00 P.M. patient again became pale, almost pulseless; 500 cc. blood given.

Consultation — Advised manual removal under anesthetic and did it. At beginning of anesthetic, patient suddenly stopped breathing and vomited large amount of dark fluid. Then reacted for a time. After placenta was delivered, gradually became worse and patient died at 9:00 P.M.

Cause of death—Retained placenta. Embolism.

#21530. D. W., age 22. Primip. Dr. A.

History—Repeated attacks of pleurisy, otherwise negative.

Delivery—Breech—after-coming head delivered with forceps. 1. Term pregnancy. 2. Breech delivery. 3. Chronic pleurisy. 4. pulmonary embolism 6th day. 5. Phlebitis. 6. Puerperal sepsis. 7. Agranulocytic anemia.

Blood Picture

Date	5-1	5-10	5-13	5-27	5-29
Hg.	68%	65%	70%	48%	34%
RBC	3900000	3760000	3600000	2190000	1800000
Leuc.	12250	13300	9600	1800	1600
Sm. Lymp.	16	28	12	94	92
L. Mon	3	4	4	....	....
Polys	67	62	78	4	5

Treatment — H.M.C. Sod. amytal; ether.

P.P. Treatment—Codeine. Ergotrate. Phenacetin, aspirin. Sulfanilamide, nembutal. Potassium permanganate douche. Lextron. Elixir terpin hydrate, sulfanilamide. Transfusion. Liver extract. 1/10 cc. amp. pentnucleotide. Blood transfusion, glucose. Above notes on treatment are taken as given on chart.

Jaundiced on 24th day postpartum.

Died on 31st day.

Cause of death—1. Puerperal sepsis, embolism. 2. Sulfanilamide poisoning.

In conclusion, we find our greatest cause of mortality to be puerperal sepsis, then hemorrhage with embolism, and toxemia following closely.

Summary of Causes of Deaths

Medical	2
Lobar pneumonia	1
Tuberculosis with endocarditis	1
Toxemia	3
Yellow atrophy of liver	1
Eclampsia	2
a—Eclampsia	
b—Eclampsia with acute nephritis	
Nephritis	1
Cerebral hemorrhage with nephritis	1
Placenta praevia	4
Retained placenta (1 with embolism)	2
Premature separation of placenta	2
Embolism	4
Spontaneous	1
Hernia	1
Tuberculosis	1
Heart Disease	1
Puerperal sepsis	9
Pyelitis	2
Questionable surgery	1
Puerperal insanity	1
Long labor	1
Transverse presentation	1
Hemorrhage of broad ligament	1
Following normal labor which could not be explained	1
Associated embolism and sulfanilamide poisoning	1

Total cases delivered 1923 to May 1, 1938	4204
Deaths	28
MORTALITY RATE	0.66%
Of these delivered prior to 1930 in old hospital	1253
Deaths	13
MORTALITY RATE	1.03%
Balance of cases delivered in new maternity	2951
Deaths	15
MORTALITY RATE	.508%
In addition to the delivered cases there were admitted to the hospital:	
Total of abortions	567
Deaths	9
DEATH RATE	1.58%
Total admissions, delivered, abortions	4771
MORTALITY RATE	0.776%
Classification of deliveries exclusive of abortions shows the following:	
Delivered by high forceps	55
Delivered by medium forceps	186
Delivered by low forceps	529
Breech, including several transverse	205
Vertex	3999
Cesarean	67
Maternal deaths	28
Newborn deaths	112
Stillbirth	154
Placenta praevia and premature separation of placenta	30
Hemorrhage	108

584 Main Street.

ONE HUNDRED YEARS OF BLADDER-STONE SURGERY

Statistics indicate a marked shift in the last century in the age distribution of patients suffering from bladder stone. At present only 11 per cent of the patients with bladder stone are less than 30 years of age.

MENTAL HYGIENE NOTES

CASE NOTES IN EXTRAMURAL PSYCHIATRY

Case VII: Stuttering in a Nine-Year-Old White Male, with a Statement of Principles in the Treatment of Speech Defects

FREDERICK L. PATRY, M.D.
Albany, New York

Complaint Problem: Was formulated by the mother as, "Stuttering when he recites—gets tangled up and can't talk." He also has habit spasms (nose sniffing and eye blinking) and is obese.

Present Illness: Facts indicate that patient was free of speech defect until the mid-term of the third grade, when he was seven years old. It was first noticed at school, and soon after mother noticed his tendency to stutter at home. This was chiefly due to the fact that the teacher spoke to patient's mother about his speech difficulty. It is mostly in the presence of strangers that one notices stuttering. However, patient is easily excitable and when such emotional states arise, for example, precipitated by the correction of examination papers, he registers protests to the strain in the form of stuttering. Rarely when he reads aloud does he stutter. On the other hand, when the teacher asks a question, even though he may know the answer, he somehow gets confused and shows the characteristic hesitant and repetitious phenomenon of speech.

Personal History: Shows that patient experienced a natural birth, the third oldest of four children. Breast fed eight months. Teething, talking, and walking well within the normal range. It is interesting to note that mother states that none of her children spoke clearly when very young, but the difficulty cleared up by the age of six. Personality is described as bashful, does not enjoy many friends, but although introverted, seems to be happy. He plays little with others, preferring to read. Past illnesses reveal mumps at age four, tonsillectomy at age five, chickenpox and whooping cough at age eight. Since September, 1937, he has been wearing glasses to correct near-sightedness and eye strain, associated with sties. At present he wears glasses while studying, but if left to himself, would spend most of his time reading. He has always been an over-sized child and definitely obese. He sleeps in a double bed with his six-year-old brother. The family lives in an apartment over a dry goods store owned by parents. Regular habits of eating, sleeping, and elimination. No sex irregularities.

Family History: Reveals a father, aged 48, well, but more engrossed in business than in taking an interest in his children. On the other hand, mother, who is in the late forties, is also obese but is over-solicitous of patient's welfare. She is definitely "nervous", revealed by marked resentment to the normal noise and conflict of growing children in the home. There are three brothers, ages 19 years, 11 years, and 6 years. The oldest obtained a college scholarship on graduating from high school and is getting along well in higher education. The second oldest child is more or less in conflict with patient, exhibited by

teasing and taking his belongings. More trouble than is indicated arises, due to the fact that patient lacks a happy give-and-take faculty.

Facts of *physical examination* reveal an over-sized, well-developed, heavy-set, obese boy who presents a lackadaisical attitude and droopy posture. Head circumference, 21½ inches. Weight, 124 pounds. Height, 60¾ inches. Thyroid, normal.

Neurological Examination: Essentially negative.

Mental Examination: Reveals a cooperative, neat, but somewhat withdrawing and timid child who smiles in an ingratiating manner. Considerable habit spasms consisting of blinking of eyes and sniffing of nose. There is considerable spontaneity with marked stuttering. Objectively he appears somewhat worried and tense, although subjectively he states he is happy. Content of thought indicates considerable intrafamily conflict, particularly with the next oldest brother, who insists on boxing with patient. He also recalled, with considerable resentment, a strapping given by father. Fears concerning getting shot or kidnapped by gangsters have been obsessing him for some time, precipitated by newspaper stories of kidnapping and gangster activities. His dreams are filled with thoughts of war and fear of being shot. Sensorium clear. Binet-Simon examination rated patient with mental age of 11 years, 6 months; chronological age of 9 years, 2 months; range of 9-14 years; I. Q. 125 (very superior).

Diagnostic Formulation: Stuttering in a sensitive introverted personality make-up, aggravated by tension in social situations, particularly in school, but fundamentally related to unresolved parent-child and sibling conflicts. Although precocious mentally, his mother has frustrated patient's social growth and independence by her over-solicitousness. This is understandable in the light of the father's somewhat tyrannical attitude toward the child, which gave rise to fears and need of emotional support from mother. His timid personality was made more jagged by his fear reactions to current events relative to kidnapping and gangster activities. Such fears and emotional tension lack an opportunity for being drained off because of his poorly balanced social-recreational habits of living. Habit spasms are on the basis of attention-gaining devices which also serve to "save his face" for underlying feelings of inferiority based upon emotional conflicts.

Prognosis: Should be good for the ultimate correction of the speech defect, provided he is given an understanding of the various facts and factors entering into the problem, together with the application of reeducational methods which will assist him in regaining ego adequacy in social relationships. Habit spasms will gradually disappear with their masterly neglect.

Treatment: The specific treatment approach took the form of winning the child's, as well as the mother's, confidence that his stuttering and habit spasm protests to emotional stress and strain could, in time, be overcome, provided they were willing to cooperate over a long-time period of analysis with re-education. Every attempt was made to reduce environmental conflicts. For this reason, it was urged that parents, particularly father, assume a more understanding and sympathetic rôle with chumming in social and recreational opportunities. Patient's self-reliance was encouraged by creating opportunities for him to run errands alone, in order that he might gain courage in facing strangers in making purchases. Summer camp was urged. Mother was cautioned to be less hovering in her practice concerning patient's welfare and allow him to fight his own battles with his brothers and others without interference. Highly charged emotional reading, as well as radio programs, were soft pedaled, particularly before retiring, as these frequently lead to turbulent dreams. Ability to defend himself and build up his social ego was fostered by purchasing boxing gloves, in order that he might try himself out in a guarded fashion with his younger brother. Parents were urged to provide patient with a single bed. Interparental disharmony with respect to

children's management was forbidden. Participation in group activities such as singing, dramatics, and dancing was encouraged. A list of general rules was given to patient and a copy was also sent to his school teacher with a summary of examination findings and recommendations.

Progress Notes: Indicated patient soon began to show marked improvement in speech. He was urged to keep away from other children who stuttered. Self-confidence was also aided by encouraging patient to telephone orders. He read aloud stories to his younger brother, and his mother sympathetically listened. The family were urged to consistently ignore patient's habit spasm expressions and not to pass derogatory remarks concerning stuttering. On the other hand, praise, encouragement, and rewards were to be utilized for relative success in group speaking. It was suggested that mother ask patient questions out of the daily newspaper in order that he might build up ready self-confidence in answering. Pride in his physical appearance and muscle power was fostered by prescribing setting-up exercises and urging him to engage in large muscle games. He was placed upon a weekly budget of which he must save part, and thus contribute to his feeling of economic security with freedom of choice in the expenditure of money. On no account were members of the household to do for patient what he could do for himself. Exciting movies were avoided, as he would easily get excited and upset. At first he would take advantage of his superior size and strength in defeating his six-year-old brother in boxing, but later his sense of values and ego were built up by allowing his brother to "beat" him. Argument with mother regarding the virtues of eating eggs and other foodstuffs was prohibited. He was allowed to choose what foods he liked without disputation. As a consequence, patient and his parents have been getting along more satisfactorily, and there have been fewer sibling quarrels.

In school there has been a marked reduction in stuttering, and there are some weeks in which it is not evinced at all. His over-impulsive nature is gradually being reconditioned so that he first gets himself into a calm frame of mind before volunteering an answer. Last June he passed third highest in his class and is now in the high fifth grade. Arrangements have been made for him to go to summer camp.

General Principles in the Treatment of Speech Defects

IT is estimated that approximately four per cent of the pupils in elementary grades have speech defects which demand special attention. It has been stated by others that eighteen per cent of school children and about as many adults are handicapped because of varying degrees and types of speech disorders.

The majority of speech defects may be corrected or greatly benefited. In order to bring about improvement we must first of all consider the facts and factors which pertinently bear on the causes of speech difficulties.

As in the case of all types of physical and mental disorders, we must consider the individual as a whole, functioning as an integrated unit. Something may go wrong on various individual or combined levels of the integrated person—for example, structural (organic), physiological (functioning of parts), or psychobiological (mentally integrated behavior). But, in any event, the person reacts as a whole and as such we must study him, including constitutional or ingrained factors as well as those of environment and experiences and the individual's reaction to them.

In the case of speech disorders, the cause may lie in:

(a) Some *structural abnormality,* either congenital or acquired; for example, deformities of the end-organs of speech, such as deformed or cleft palate, harelip, missing or deformed teeth with faulty occlusion, abnormality of lips or tongue, defects in the larynx (voice box), or obstruction of, injury to, or abnormal growths in the nose, throat, or pharynx, such as diseased tonsils and adenoids. Muscular weakness in the

tongue, lips, and soft palate may also result in faulty speech utterance or defect, such as "nasality," "baby talk," "lisping," and "lolling." Imperfect hearing may also result in imperfect speech, since we learn to speak largely through imitation.

(b) Some *functional defects*— for example, faulty habits of breathing, enunciation, and utilization of speech organs, faulty learning and imitation as in family peculiarities of foreign accent or dialect. General debility and lowering of muscular tone after an illness, and also malnutrition, may be contributing causes. There is also some evidence pointing to interference with left-handedness as a more or less leading cause of stuttering in certain individuals.

(c) Some difficulty more or less on the *mental level* (psychogenic), such as emotional conflicts, fears, shocks, and other complex experiential data which, operating during a period of stress or strain, or in certain types of constitutions, have so sensitized the individual that ideas, memories, anticipations, imaginations, or associative factors cause interference with the harmonious working of the speech function. Such causes especially operate in stammering (hesitation and difficulty in making a sound) and stuttering (repetition of the first sound).

In the "stutterer" we usually encounter an individual who is possessed of immaturity of make-up, which in turn represents an expression of lack of organization of the personality. Moreover, such persons are prone to have hereditary, constitutional, or ingrained factors of emotional instability. When confronted with certain life adjustments which are accompanied by varying amounts of stress or strain, such as when first entering school or employment, or talking before a group, there tend to develop psychopathic tendencies as evidenced in stuttering.

The treatment of speech defects rationally lies in the removal of the cause, or rather causes, since there are usually several causative factors at work. In the case of structural defects, surgical treatment may be desirable or necessary. Special attention should be paid to the ears, nose, and throat. Where functional difficulties obtain, we must pay particular attention to remedial speech work by good habit training in the proper use of the organs of speech and their accessories, as well as in giving attention to the environmental factors, such as the removal of stress and strain in the form of excitement, gratuitous criticism, or poor speech example in others.

The treatment of stammering or stuttering is based on a study of the whole personality. We must know the facts of the individual's constitutional equipment and his life experiences and reactions to them, especially those experiences which were emotionally highly tinged and which left an indelible impression, consciously or not, on the immediate center of awareness. Reliving of past experiences under critical guidance as in a "distributive analysis" is effective in desensitizing the sufferer of those "sore spots" which may be playing a leading rôle in causing the speech defect. In such an analysis we should pay particular attention to the person's attitude toward life, since we often find an immaturity of ambition and unwillingness to adjust to life as it is.

Keeping in mind the above method of approach to an intelligent and comprehensive interpretation and treatment of various types of speech defects, let us formulate a few *general rules* which experience has found to be helpful in correcting such disorders:

1. Gain the confidence, good will, and desire of the person to correct his difficulty. Convince and reassure him he can get more or less rid of his handicap if he is willing to put forth a persistent effort.

2. Surround him with a sympathetic, calm, understanding, and encouraging atmosphere.

3. Ignore his speech shortcomings and make occasion to praise and reward him whenever improvement takes place.

4. Never correct him in the presence of others.

5. Do not call upon him to speak before a group, but encourage him to volunteer.

6. Urge him to relax his abnormal muscular tension and become at ease,

then think the sounds before attempting to say them.

7. Urge him to pronounce every word slowly, distinctly, and correctly.

8. Writing the first letter of each word in a sentence will assist the stutterer to overcome the tendency to repetition of the first sound.

9. Secure the cooperation of parent, teacher, and others in intimate contact with the child in not only creating an encouraging, sympathetic attitude toward the child but also in assisting him in practicing at home and at school special speech corrective exercises. At the same time, the child should be led to realize that he himself is the chief agent in getting well.

10. Speak and study aloud during study periods, as silent practice is of little value in overcoming a speech defect. The use of a mirror will be of assistance in bringing about the proper use and position of certain speech end-organs.

11. Do not interfere with changing the function of the dominant hand, such as urging the left-handed individual to write with his right hand. Where ambidexterity or uncertainty exists as to which hand is dominant, note which hand is usually used to throw objects or to comb the hair. Make occasion to utilize to the full the same arm in various games and sports activities.

12. Tactfully seek to give the individual an understanding of the causes and sources of stress and strain which contributed to the stuttering habit. Since these are largely environmental emotional factors, the individual should be assisted in gaining good habits of emotional control. The social environment should be devoid of a highly charged emotional atmosphere, and except in utilizing encouragement, praise, and reward, it should totally ignore the speech difficulty.

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214 STATE STREET.

CANCER OF THE GASTRO-INTESTINAL CANAL

The problems in treatment are well understood and have been largely mastered. The greatest need at present is early diagnosis. The thoughts we would like to leave with you are that cancer in its early stages is curable; cancer in a more advanced stage may still be curable; and that every patient with a positive diagnosis of carcinoma of the gastro-intestinal tract is entitled to an exploratory operation, if his general condition permits.—CARL EGGERS, M.D. In *Bulletin of The New York Academy of Medicine*, June, 1938.

CARCINOMA OF THE PROSTATE

Furthermore, in analyzing the results of any method of treatment there should be taken into consideration other factors more than the length of time that the patient survives. It has been aptly said in comparing results of various procedures that whereas more patients may live because of a certain procedure, more patients might also wish they had died. In our experience the most potent encouraging benefaction accruing to the patient upon whom successful transurethral resection has been performed is the will to live.—G. G. REINLE, M.D. In *Urologic and Cutaneous Review*, July, 1938.

CANCER

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THE ENDOCRINE RELATIONS OF *Cancer*

VII

The Thymus Body

IN 1922 Hoskins (7) wrote: "The researches of recent years have more and more tended toward a conclusion that the thymus gland has no true internal secretion."

In 1927 Warthin (18) wrote as follows: "Of the function of the thymus we have as yet no definite knowledge. * * * Various writers have asserted that the thymus possesses certain vegetative functions, particularly in connection with the development of the bones, central nervous system, sexual apparatus, and the general metabolism; and numerous attempts have been made to establish the thymus as an organ producing an internal secretion."

In 1936 Rowntree, Clark, Steinberg and Hanson (14) reported the results of their experiments with an extract of thymus of calves. This extract was made by Hanson (6-b) and was originally called karkinolysin. Its method of production was described in 1930. He employed a technique that removes the fibrous tissue of the gland and the lymphoid elements so that the extract is free from nucleohistone. Each cubic centimeter of the extract represents 0.6 gm. of the fresh gland of young calves and has a protein content of about 2.0 per cent.

The extract is potent and is found to be rich in sulphydryl compounds, expressed in terms of glutathione. It is of maximum potency when the pH is between 3.8 and 4.2. It is not yet definitely determined whether the active principle is glutathione, cysteine, cystine or glutamic acid. However, as a result of the injection of Hanson's extract into pregnant rats, the average weight of the young is increased, the ears and the eyes open earlier, the incisor teeth erupt earlier (in the seventh generation and on they are erupted at birth), the hair begins to grow earlier, the testes descend earlier, the vagina opens earlier and the females become pregnant and cast their first litter earlier. On the other hand, thymectomy in young animals is followed by a definite retardation of growth, which can be more than compensated by the injection of thymus extract, as well as by homologous implants. In normal rats thymus implants accelerate the rate of growth of the young animals.

So, apparently, it is necessary to revise the early view of the function of the thymus and to credit it with a definite influence on general growth and especially with an influence on the development of the anatomical and physiological characteristics of the reproductive system.

Frequency and Classification of Thymus Tumors

EWING (4) classifies malignant tumors of the thymus as lymphosarcoma or thymoma and carcinoma. There may be a "very rare and somewhat questionable" tumor called spindle cell or myxosarcoma. He is of the opinion that both thymoma and carcinoma arise from the reticulum cells of the organ.

Crosby (2), in a review of 165 cases of malignant tumor of the thymus gland found that 121 were sarcomata and forty-four were carcinomata. He reports an additional case of sarcoma.

Symptomatology and Diagnosis

EDWARDS (3) suggests the following studies before the existence of an intrathoracic tumor can be determined: (1) Röntgen examination of the chest from the anteroposterior, lateral, and oblique aspects; (2) Further röntgen examination after artificial pneumothorax or the replacement of an effusion by gas; (3) Bronchoscopy with iodized oil; (4) The examination of a pneumothorax cavity when possible by the thoracoscope.

In all cases of bronchial obstruction and of hemoptysis, when the sputum contains no acid fast bacilli, bronchoscopy is indicated. He says: "The hope of satisfactory treatment of all types of intrathoracic new growth, benign or malignant, depends on early diagnosis."

McDonald (10) reports a case in a man, aged 59 years, who complained of pain in the back, indefinite dysphagia, dyspnea and "shivering." At autopsy a cystic tumor was found immediately below the great vessels, which, histologically, was composed of large cells with pale nuclei and smaller cells with deeply staining nuclei. The tumor was thought to be a "reticulum cell carcinoma" of the thymus.

He is of the opinion that carcinoma of the thymus originates from the reticulum cells. He says that the presence of Hassall's corpuscles in these growths is not a necessary criterion for thymic origin.

Kahr (8) reports a case of carcinoma of the thymus in a woman, aged 41 years, who had had five children and was in the fourth month of her sixth pregnancy. This patient also presented a severe osteomalacia, confirmed by x-ray study. At autopsy extensive metastases were found in the skeletal system, particularly in the vertebrae, and in the lymphnodes and the suprarenal body. He is of the opinion that the osteomalacia was the result of the metastases. On the other hand, Scipiades (15), in criticizing Kahr's conclusions, felt that the osteomalacia was the result of the destruction of the thymus by the carcinoma and that the softening of the vertebrae presented a favorable ground for the development of the metastatic growths.

SLESINGER (17) says that the clinical picture of all thymic tumors is the same. There is nothing to distinguish a carcinoma from a lymphosarcoma, except that the latter is sometimes radiosensitive.

The subjective symptoms are mediastinal pressure, cough, hoarseness, dyspnea, cyanosis, and edema of the neck and the face. Exophthalmus and dysphagia have been described. On physical examination, retrosternal dullness and sometimes a pericardial effusion may be demonstrated. Röntgen study will show a tumor in the superior mediastinum. The tumors, particularly the lymphosarcomata, present symptoms similar to those of myasthenia gravis.

The author reports a case in a man, aged 49 years, who complained of dyspnea and swelling of the face and the neck of about four weeks' duration. Röntgen study showed a tumor in the upper portion of the chest. At autopsy the tumor was found in the region of the thymus gland, and was diagnosticated histologically carcinoma.

Norris (13-b) reports the case of a farmer, aged 52 years, who died after a rather indefinite illness of four years' duration. At autopsy a tumor of the

thymus was found which was associated with the histological lesions of myasthenia gravis.

He had previously reported (13-a) four cases of myasthenia gravis, two of which were associated with "a high degree of hyperplasia of the thymus." He had also found reports of eighty cases of myasthenia gravis in the literature, thirty-five of which presented lesions of the thymus body.

The Influence of Thymus on Malignant Tumors

WRITING under the title: "Cancer as a Problem in Metabolism," Beard (1) reached the conclusion that the rapid growth of some tissues is evidently associated with the glands of internal secretion, especially with the thymus.

In 1930 Hanson (6-a) reported four cases of inoperable cancer treated with intramuscular injections of karkinolysin. The treatment was based on the hypothesis (The author said: "I do not even designate it as a theory") that the giant epithelial cell of the thymus is the true thymus and that it controls the correct, normal and healthy rate of epithelial mitosis and cell division. It was administered in 1.0 cc. doses daily for from three to six months, or thirty days after all clinical evidence of the disease had disappeared. The first case was one of annular adenocarcinoma of the splenic flexure of the colon in a woman aged 56 years, who survived more than four years and who died of pneumonia during the fifth year. The second case was one of adenocarcinoma of the greater curvature of the stomach in a woman, aged 42 years, who, when last heard from, "was in good health." The third case was one of metastatic carcinoma of the retroperitoneal lymph-nodes (primary tumor not determined) in a man, aged 35 years, who was living one year after the treatment. The fourth case was one of papillary carcinoma of the ovary with metastases to the peritoneum, in a woman aged 49 years who was also alive one year after treatment.

In 1931 Simpson and Marsh (16) used the thymus extract made by Hanson and called karkinolysin in the treatment of three albino mice with spontaneous adenocarcinoma of the breast. They found no evidence of therapeutic action.

In the same year Meyer and Simmons (12) treated mice with transplanted C 63 carcinoma with karkinolysin but found no obvious effect on the growth of the transplants. There was no demonstrable difference, postmortem, between the tumors and the viscera of the treated and the untreated animals.

ATTENTION is invited to the statement made by Rowntree and his co-workers (14) that the thymus extract made by Hanson deteriorates easily and becomes inactive.

Gruhzit (5) found that treatment of albino rats bearing the Flexner-Jobling carcinoma and the Jensen sarcoma with thymus extract neither inhibited the growth of the tumors nor caused them to regress nor did the injections prolong the lives of the hosts. Karnicki (9) found that intravenous injections of thymus and testis preparations caused the nodules of tar cancer of the ears of rabbits to dry out, and, in the smaller growths, to disappear. In the larger nodules softening and diminution in size were noted.

Maisin and Pourbaix (11) found that thymus extract inhibited the growth of tar cancer. The growth inhibiting substance was soluble in ether; but relatively insoluble in acetone.

Karnicki (9) found that removal of the thymus was followed by an acceleration of the development of tar cancer of the ears of rabbits. In some instances the tumors grew four times faster in the animals in which the thymus had been removed. Stimulation of growth was observed in animals in which the testes were removed at the same time that the thymus was removed. He was positive that the absence of the thymus or its hypofunction influenced the development and the growth of these cancers.

Summary

INJECTION of gland products produced no effect: Gruhzit (1931); Simpson and Marsh (1931); Meyer and Simmons (1931). Inhibited growth: Karnicki

(1932); Pourbaix and Maisin (1935). Gave beneficial results at the hands of Hanson (1930). Removal of the organ accelerated the development of tar cancers: Karnicki (1932). Tumors of the thymus are associated with osteomalacia: Kahr and Scipiades (1936) and myasthenia gravis: Norris (1936 and 1937).

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ERGONOVINE VERSUS ERGOTAMINE IN MIGRAINE HEADACHES

Each patient with migraine must be treated as an individual. There are tractable and intractable headaches. There is a powerful migraine pain killer (ergotamine) and one which is relatively weak (ergonovine). An elephant gun should not be trained on a rabbit and, if ergonovine proves effective, there is no need to prescribe ergotamine. Patients who find ergonovine effective usually prefer it, either because gastro-intestinal symptoms are not so pronounced or because relief follows oral administration. Ergotamine does not seem to have strong action as an abortifacient. Several migraine patients have continued to use it in pregnancy without ill effect. Ergonovine, on the other hand, should not be used during pregnancy. W. G. LENNOX, M.D. In *American Journal of the Medical Sciences*, April, 1938.

THE TOXEMIAS OF PREGNANCY

It is possible that in a lack of balanced function of the pituitary-adrenal complex and of its sympathetic nervous connections, influenced by the ovary, the thyroid and in pregnancy by the placenta, we may uncover the nature of at least some of the various disturbances we now call the toxemias of pregnancy. As yet, however, we cannot subscribe without reservations to that which often seems to have more of shadow than of substance.

While awaiting the essential additions to our knowledge of physiology the clinician must continue his bedside observations which should include the entire life history of the patient and of her disease. Already in collaboration with the obstetrician and the pathologist much light has been thrown upon the problem and more is promised.—W. W. HERRICK, M.D. In *Bulletin of The New York Academy of Medicine*, July, 1938.

Contemporary Progress

Medicine

The Na/Cl Index of the Urine in Diseases of the Liver

H. W. Bansi and G. Strecker *(Zeitschrift für klinischen Medizin 134:410, July 6, 1938)* report a study of the excretion of sodium and chloride, determined separately, in the urine and the Na/Cl index in various diseases of the liver (42 cases). They found that in cirrhosis of the liver, there was a definite diminution in both sodium and chloride excretion and a Na/Cl index much below normal. The lower this index, the more serious was the prognosis in these cases. In carcinoma or sarcoma with marked invasion of the liver parenchyma, there was also a low Na/Cl index and diminution in the excretion of both sodium and chloride. In catarrhal jaundice the index was lowered during the height of the disease; as the jaundice subsided there was a marked increase in sodium excretion, raising the index above 1. In obstructive jaundice, the index was within normal limits, but showed considerable variation. Characteristic changes in the sodium and chloride excretion were observed only when all sections of the liver parenchyma were involved.

COMMENT

Worthy of further observations.

M.W.T.

The Oxygen Therapy of Pneumonia

G. H. Faget and W. B. Martin *(Annals of Internal Medicine, 12:32, July, 1938)* report the routine use of oxygen in the treatment of pneumonia at the U. S. Marine Hospital, Norfolk, Virginia. In this hospital, oxygen has been employed for the last five years, not only in the treatment of seriously ill patients, but in all cases of pneumonia, beginning the treatment as soon as the diagnosis is established and continuing it throughout the course of the disease. An oxygen tent is employed, and oxygen admitted so as to maintain a concentration of 40 to 60 per cent. This routine use of oxygen was begun in the spring of 1931. The mortality for pneumonia for that year in the hospital was 26 per cent, 33.3 per cent without oxygen, 16.6 per cent with oxygen. The objection might be raised that the seasonal distribution influenced the good results in this year. For the four years preceding 1931, when oxygen therapy was not routinely employed, the mortality for lobar pneumonia averaged 32.65 per cent, that for bronchopneumonia 28.95 per cent. In the five years following 1931, the mortality for lobar pneumonia was 18.75 per cent, for bronchopneumonia 16.7 per cent. Cases of "terminal pneumonia" are excluded for both periods. The authors have not observed the course of the disease to be shortened by oxygen therapy; but cyanosis is lessened, the patient becomes quieter, breathes more easily and often "falls into a restful sleep" under oxygen therapy. The general condition is definitely improved. It has been noted that patients when temporarily removed from the oxygen tent request to be placed under it again.

COMMENT

As more of this work is done it will be possible to evaluate this method of treatment with continued use throughout the disease.

M.W.T.

Gastro-Intestinal Disorders Simulating Heart Disease

J. A. Lyon *(Southern Medical Journal 31:902, Aug., 1938)* notes that certain gastro-intestinal conditions may give rise to cardiac symptoms, such as syncope, weak pulse, arrhythmia and substernal pain, when there is no cardiac disease. He reports 2 cases of pyloro-

spasm in which such attacks occurred; the attacks were always related to food and were relieved by vomiting large quantities of fluid. Neither patient showed any evidence of "cardiac incompetency", and in both a diagnosis of pylorospasm was made. Cardiospasm may also produce symptoms simulating an acute heart attack. In the early stages pain in the lower substernal region may be the only symptom. Gastro-intestinal upsets induced by indiscretions in diet, especially in elderly people, may cause symptoms simulating an acute attack of coronary thrombosis; in such cases symptoms are relieved by inducing vomiting and emptying the stomach. The accumulation of gas in the stomach or intestines due to dietary errors, overeating or "nervous influences" may produce mild cardiac symptoms. Why a gastro-intestinal "upset" causes predominantly cardiovascular symptoms in some cases and not in others "we do not know." The presence of arteriosclerosis or hypertension or cardiac neurosis or a labile nervous system may be a factor. The author has noted that when severe cardiac symptoms arise from gastro-intestinal disorders, the patient is in collapse or shock. This may be due to dehydration, which often accompanies such disorders and especially pylorospasm.

COMMENT

The general practitioner is often confronted with patients complaining of symptoms which simulate coronary disease. In one instance I saw a patient who had what seemed to be almost a classical thrombosis and it proved to be due to a spastic duodenum. No doubt pylorospasm may simulate coronary disease, especially those symptoms which are due to dehydration. Recently I spent six hours with a patient before I could decide whether she was having a coronary attack or not. It often taxes the ingenuity of the physician to decide. A drop in blood pressure, fever, and leukocytosis helps in the diagnosis. But it is possible to get a leukocytosis and fever from an intestinal infection. Almost all gastro-intestinal upsets show definite blood changes which suggest infection. It would seem that these cases reported are exceptions; most patients with syncope, weak pulse, arrhythmia, and substernal pain have coronary thrombosis.

M.W.T.

Treatment of Subclinical and Classical Pellagra with Nicotinic Acid

T. D. Spies, W. B. Bean and R. E. Stone *(J. A. M. A. 111:584, Aug. 13, 1938)* note that C. A. Elvehjenn and his associates found that nicotinic acid cures black tongue in dogs; this resulted in the trial of nicotinic acid in human pellagra by several investigators. Spies, in collaboration with Cooper and Blankenhorn reported the use of nicotinic acid in 17 cases of pellagra in February 1938. In this article Spies and his associates report the use of nicotinic acid, its sodium salt (sodium nicotinate), and nicotinic acid amide in the treatment of 73 cases of pellagra; of these 46 had endemic pellagra, 16 pellagra developing after malnutrition resulting from other diseases, and 11 pellagra after chronic alcohol addiction. All the patients had lesions of the mucous membrane diagnostic of pellagra and 56 had characteristic pellagrous dermatitis; all had lost weight, strength and appetite; 51 had mental symptoms;

and 40 had diarrhea. It was found that the administration of adequate doses of nicotinic acid, the amide or sodium salt, results in healing of the pellagrous glossitis, stomatitis, vaginitis, urethritis and proctitis, blanching of early erythematous lesions; and relief of gastrointestinal symptoms. A marked improvement in both early and late mental symptoms was also observed. The diethyl amide of nicotinic acid (coramine) had "somewhat similar therapeutic properties" but the methylbetaine of nicotinic acid (trigonelline) was inactive. In 199 pellagrins without clinical symptoms of the disease, but subject to one or two recurrences annually, the recurrences were prevented and the general condition improved by daily oral administration of nicotinic acid. A study of the children in several hundred "pellagra families" showed that "a slowly progressing deficiency in the antipellagra factor" was usually present although active symptoms of pellagra did not develop till later. The administration of nicotinic acid definitely improved the general condition of these children and relieved such symptoms as were present. In most cases the oral administration of nicotinic acid or its derivatives gives best results except in the few cases in which the patient is unable to ingest or absorb it by this route. The dosage required is variable, but 500 mg. daily in divided doses is usually effective and sometimes smaller doses give "dramatic relief", but in other cases larger doses are required. While nicotinic acid is effective without further treatment, results are better if patients with active or subclinical pellagra are also given a well balanced diet, ample rest in bed, and treatment for any coexistent diseases.

COMMENT

These are interesting observations. Will nicotinic acid prevent pellagra? My impression is that nicotinic acid is more satisfactory as a curative agent than as a preventive one. For the prevention of pellagra perhaps a rounded diet plus powdered yeast is still the most satisfactory regimen.

M.W.T.

Bile Salt Therapy in Gall Bladder Disease

H. DOUBILET, H. YARNIS and A. WINKELSTEIN *(American Journal of Digestive Diseases 5:348, Aug., 1938)* report the use of a low fat, low carbohydrate, high protein diet and bile salts in the treatment of gallbladder disease of various types. The patients were required to take their meals at regular hours and not to eat between meals. The bile salts were given in the form of an iron salt of ox bile acids in capsules of 5 grains each. The capsules were given with each meal during the meal. The initial dose was one 5 grain capsule at each meal; the amount was increased as necessary to secure at least one bowel movement and not more than two daily. This treatment was used in three groups of patients. The first group included 13 patients with post-cholecystectomy symptoms. Of this group all but one were relieved of dyspeptic symptoms and constipation; 6 were entirely relieved of pain and 4 considerably relieved. In one of the cases with no relief of pain it was due to spondylitis and radiculitis, in another possibly to pancreatitis (left upper quadrant pain). The second group consisted of 14 patients with functioning ballbladders containing stones, as demonstrated by cholecystography. In all these cases dyspepsia and constipation were relieved; 8 patients were entirely free from attacks of pain; in 4 patients the attacks were less severe and less frequent. One patient had marked hyperacidity and required alkalies and atropine in addition to the bile salts for relief of pain. In one case in which attacks continued, operation showed a small stone in one of the valves of Heister in the cystic duct. The third group consisted of 11 patients in whom the gallbladder could not be visualized in the cholecystogram, and the presence or absence of stones could not be determined. Dyspepsia and constipation were relieved in all cases; 2 patients showed marked relief and 8 patients entire relief from pain; in one case the attacks of pain were caused by "dietary indiscretions". The bile salt therapy is not effective where there is mechanical obstruction by stone in the common or cystic duct. If a common duct stone is

present, the increased flow of bile may cause attacks of pain or even jaundice, as noted in cases previously reported but not included in this series.

COMMENT

Perhaps the laxative effect of bile salts has some part in the relief of symptoms.

M.W.T.

+ Surgery +

Partial Cholecystectomy

W. L. ESTES, Jr., *(Archives of Surgery, 36:849, May, 1938)* notes that the operation of choice for acute or chronic cholecystic disease is cholecystectomy. When there is a massive inflammation and induration about the common and cystic ducts, any type of complete cholecystectomy may be technically difficult, and also attended with difficulty in controlling hemorrhage, and "an unduly high mortality." In such cases of severe suppurative or gangrenous gallbladder disease, the author has found partial cholecystectomy of value. The technique used by the author is described, and a review of other methods of partial cholecystectomy is presented. With the author's method, the gallbladder is aspirated of its fluid contents; the fundus is incised and stones removed, and the gallbladder dried and swabbed with tincture of iodine. It is then split with scissors to within 1 to 2 cm. of the cystic duct and partially removed by trimming off the redundant part of each half down to the border of the fossa of the liver; bleeding from the cut edges is controlled by ligature or lock stitch up each side. Cigaret drains are placed at the opening of the cystic duct, brought out against the remnant of the gallbladder, then either through the operative wound or through a lateral stab wound directly over the gallbladder remnant. The author has used this method in 48 cases in fourteen years; in 44 cases it was used because of an acute suppurating or gangrenous bladder with induration about the cystic or common duct; in 4 it was used because of "extremely difficult exposure" of a small contracted gallbladder densely adherent to the liver. In these 48 cases, there was one death, a mortality of 2.08 per cent.; death was due to pulmonary embolism in a patient with advanced myocardial disease. A follow-up examination of 42 of the patients recovering from operation show, that 34 (81 per cent.) have remained well and free from symptoms referable to the gallbladder for periods of up to twelve years; 5 require slight dietary restrictions (especially fat restriction) because of occasional bloating and belching after meals; 3 have required subsequent operation for stones in the common duct, six, eight, and nine years respectively after the partial cholecystectomy; in one of these cases re-operated by the author, "no vestige of anything that even resembled the gallbladder" was found. In 2 other cases of the series, in which the author subsequently did a hysterectomy, palpation of the gallbladder region showed no evidence of any reformation of the gallbladder. Partial cholecystectomy, the author concludes, has "a very restricted field," but in cases where it is definitely indicated it gives good end results, and "a surprisingly low mortality."

COMMENT

Here is presented, in a masterly manner, the experiences of a sound conservative surgeon in the desirable early excision of acutely inflamed gallbladders without insisting upon subjection of the patient to maximum unnecessary risks. We have used a similar technique several times with complete satisfaction. We can recall instances where it would have been better than the complete cholecystectomy accomplished. Dr. Estes' procedure is so well ordered and explained that every maturing surgeon should have it available upon the occasions which make it especially advantageous to a patient in acute danger. On many such occasions it may be life-saving or provide future freedom from disability and pain. Unquestionably a few cases of stone in the common duct will eventuate in any considerable series. These cases can be more safely managed later when the acute infection has long passed.

C.H.G.

Cholangiographic Demonstration of the Remaining Common Duct Stone and its Non-Operative Management

R. R. BEST *(Surgery, Gynecology and Obstetrics, 66:1040, June, 1938)* states

that since he has made delayed cholangiographic studies in all cases with common duct drainage or biliary fistula after cholecystectomy, he has found that the usual methods of exploration of the common duct do not reveal all the stones that are present in the duct. It should be remembered also that these remaining common duct stones may be stones that have descended from the liver. The author's cholangiographic studies have convinced him that symptoms persisting or arising after an apparently successful cholecystectomy may be due to "remaining stones, mucous plugs, blood clots, or organized debris within the intrahepatic or extrahepatic biliary ducts." When delayed cholangiography demonstrates such stones or foreign bodies after operation, the following three-day regimen is carried out: On the first day a 1/100 grain tablet of nitroglycerin is dissolved under the tongue three times during the day; on the second day, 1/100 grain atropine is given three times, either by mouth or hypodermically; on the third day, the nitroglycerin is repeated. Each morning the patient is given 2 drams or more of magnesium sulphate in warm water and at bedtime an ounce of olive oil or thick cream. The common duct is irrigated gently every day through the drainage tube or fistula with warm normal saline solution, and after as much of this fluid is removed as possible with the syringe or by permitting the tube to drain for five minutes, 10 to 30 c.c. of warm sterile olive oil are instilled; or lipoidine or lipiodol may be more beneficial for instillation. If it does not cause the patient distress the tube should be clamped off during this course of treatment, except for one hour after each instillation of oil. In addition 3 to 5 decholin or procholon tablets (3¾ grain) are given four times a day to increase and maintain pressure within the common duct. This treatment may be repeated after an interval of a day or more; in one case reported it was given ten times in a period of two months. With this treatment, stones are often demonstrable in the stools; if not, repeated cholangiography before the drainage tube or fistula is closed will demonstrate when the stone or foreign body has disappeared. The dehydrochloric acid products should be prescribed with caution if any degree of jaundice is present. This method of "postoperative biliary tract flush," the author is convinced, is of definite value in avoiding the so-called postcholecystectomy syndrome.

COMMENT

This is a clinical story of the cholangiographic demonstration of common duct stones after cholecystectomy with thorough investigation of the common duct. Added to this is a novel method of treating such calculi. We should prize further contributions from this author or his disciples. His results seem most satisfactory.

C.H.G.

The Insensible Loss in Surgical Patients

W. W. FUGE and B. M. HOGG *(Annals of Surgery, 108:1, July, 1938)* report a study of the insensible loss in 12 surgical patients having 14 operations. This insensible loss was found to range from 1,154 to 1,830 gm. daily; the average insensible loss for 175 twenty-four hour periods was 1,457 gm. per period. It varied in accordance with the weight and size of the patient rather than with the extent of the surgical operation. The insensible loss for all the cases averaged 39.4 per cent. of the total output. From a clinical standpoint this insensible loss may be considered as water loss since the loss due to CO_2 and O_2 exchange is relatively small. It is evident, therefore, that in considering the amount of fluids to be given a surgical patient, the insensible loss is sufficient to deserve attention, yet the determination of the fluid to be given a surgical patient is usually based on the appearance of the patient and the amount of intake and output recorded on his chart for the previous day or days. "Respectful attention" is given to the urinary output for the preceding twenty-four hours. An illustrative case is reported in which collapse due to serious dehydration occurred (with high specific gravity of the blood). In this case the urinary output was considered satisfactory and the administration of fluids was stopped on the eighth day. In determining the fluid needs of the surgical patient, especially after operations

where fluids cannot be given by mouth for several days, the insensible loss, estimated from the weight and size of the patient, should be compensated for, as well as the other fluid losses involved.

COMMENT

This is a carefully conducted study and should lead to more intelligent postoperative administration of fluids.

C.H.G.

The Function of the Spleen in the Retardation of Shock from Hemorrhage

E. P. LEHMAN and C. V. AMOLE *(Surgery, 4:44, July, 1938)* note that according to "common surgical tradition" the removal of the spleen involves no serious handicap to the patient after a few months. It is believed that other portions of the reticulo-endothelial system take over the functions of the spleen to a great extent. There is one function of the spleen, however, that these other tissues cannot assume—the so-called "reservoir function," by which the spleen can store blood and deliver it promptly to the circulation when there is a physiologic demand for more blood. In experiments on dogs, the authors found that the splenectomized animal tolerates repeated withdrawals of blood less well than the normal dog. The blood pressure curve drops "more sharply" and return of blood pressure to normal level after each bleeding is less apt to recur; the "shock level" is reached with a smaller blood loss; and death ensues earlier. These experimental findings cannot be applied directly to clinical conditions in man, but they certainly suggest that the person who has lost his spleen should be considered a somewhat poorer risk for operation or accidental trauma on that account; an earlier development of shock with a smaller blood loss should be anticipated as a possibility in such patients. Surgeons should "cease to assume that the removal of the spleen definitely does not affect the chances of survival under all circumstances."

COMMENT

Here is evidence proving that animals cannot resist shock or hemorrhage as well after losing their spleens. The importance of the observations to humans is not proven but is suggested.

C.H.G.

Treatment of Infected Wounds with Superheated Antiseptic Vapor

G. A. HENDON *(American Journal of Surgery, 41:119, July, 1938)* notes that ordinary antiseptics as now applied do not reach the infecting bacteria in lacerated and widely infected wounds nor in body cavities such as the pleural cavity. Pleural sinuses resulting from empyema and bone sinuses in osteomyelitis may discharge for months and years in spite of repeated operations. He has accordingly devised an apparatus for introducing a heated and antiseptic substance into the "most distant recesses" of such wounds. The heated air in the apparatus is pumped into the antiseptic chamber where it vaporizes the chemical employed. The author has found iodine crystals preferable to other chemical antiseptics tried for this purpose. The amount of pressure used in pumping the antiseptic vapor into the wound is regulated by the sensation of the patient. It should not cause pain. Provision is made for the escape of the vapor after it has permeated the wound or cavity. The heat coil of the apparatus can be heated to 240° F. without raising the temperature of the air or vapor sufficiently to injure the tissues. The patient's body temperature rises after the introduction of the heated vapor into the wound, usually to about 103° F., but goes down to normal in twenty-four hours. Treatments may be given daily or every other day for from ten to twenty-five minutes. The discharge ceases and the wound closes in a period of one to two weeks as a rule, but a longer period may be required if the infection has been prolonged. Five illustrative cases are reported in which this treatment gave good results.

COMMENT

The author modestly calls this a preliminary report. Untoward reactions are carefully detailed by the author, as are the precautions which he deems wise. His work has been so successful as to make further reports very desirable. In the meantime others can readily extend these observations.

C.H.G.

Urology

Serum Sulphate and Blood Urea in Prostatic Hypertrophy with Urinary Obstruction

H. C. HABEIN, G. J. THOMPSON and E. G. WAKEFIELD *(Surgery, Gynecology and Obstetrics, 66:994, June, 1938)* have observed in previous studies that serum sulphate may be increased in early renal insufficiency before the blood urea. In a study of the serum sulphate and blood urea in a series of cases of prostatic hypertrophy with urinary obstruction, the authors found the serum sulphate increased without increase in the blood urea in 19 cases. All these patients had hypertension and arteriosclerosis, but little or no residual urine. In 31 cases, the blood urea was above normal, but the serum sulphate was normal; in all these cases the blood urea was brought to normal by the administration of fluids; these patients made good recoveries after surgical relief of the obstruction. In 70 cases both the blood urea and the serum sulphate were above normal; this indicates a more serious degree of renal impairment. It was found to be more difficult to reduce the serum sulphate to normal than the blood urea.

COMMENT

In dealing with tests of the constituents of the blood it seems more or less inconclusive to rely on two in correlation but independent of all the others. It is not many years since much was written about the adequacy and reliability of creatinine as the substance holding the key of renal health. Later studies showed that, if anything, creatinine was the least trustworthy because its range of variations was the most sensitive and wide. It is far more wise to take the blood as a whole and not two or a few of its elements. The margin of certainty is too narrow.

V.C.P.

Automatic Bladder Lavage

W. F. McKENNA *(Journal of Urology, 40:276, August, 1938)* describes an apparatus for bladder lavage "with adjustable regulation of the time-interval, the quantity, and the pressure factors." There are three units in this apparatus: A supply reservoir with the attachment to govern the rate of flow, a delivery reservoir to determine the quantity of flow, and the irrigating system. The important part of the irrigating system is the "self-breaking" syphon; it consists of two pieces of glass tubing; the first piece is bent at its upper end into an arch with a very short arm; the second piece is made of a short length of the same size tube as the first piece, with a slightly larger glass tube fused around it, so that the space between the two is capillary. In the upper part of this enveloping tube, there is a small hole opening into this capillary space. The upper part of this unit is joined by rubber tubing to the end of the arch of the first piece. As this system depends on gravity for its operation, which involves the introduction of air, an air-pass t-tube is incorporated to prevent the entrance of air into the bladder. In the operation of this apparatus, although it is automatic, a number of factors must be considered. The patient's own urine is added to the outflow from the bladder; the rate of outflow, therefore, should be "about half as fast again" as the rate of inflow from the supply reservoir. A brief rest period should be allowed between irrigations. The capacity and irritability of the bladder should also be considered. "A totally inert" bladder will hold 200 to 300 ml. without "muscular response". but a highly irritable bladder will not hold more than 50 to 100 ml. If the apparatus is to be used for an irritable bladder, an overflow may be used.

COMMENT

Of special and more or less complicated apparatus for drainage or lavage of the bladder there seems to be no end. Thus far none has been produced which has remained in use for many years. While probably giving more trouble to the surgeon the catheter and hand syringe have never been totally supplanted. The bladder is a sensitive and irritable viscus when diseased and in need of lavage. The syringe affords the measured quantity of fluid suitable for its changed capacity and skill with the syringe provides gentleness of inflow and the catheter gives

slow outflow adapted to its irritability. I cannot see the wisdom of any purely mechanical device for so variable and difficult a treatment as lavage.

V.C.P.

Skin Tests that Aid in Urological Diagnosis

F. H. REDEWILL *(Urological and Cutaneous Review, 42:502, July, 1938)* notes seven skin tests that are of "particular interest to urologists." These are: 1. The Antuitrin-S skin test for the diagnosis of teratoma of the testis. In 2 cases of proven teratoma recently observed by the author, the diagnosis was made "in advance" by the use of this test. 2. The author has found the Corbus skin test for gonorrhea using autoclaved filtrate of value in the diagnosis of obscure cases in women and children and also in following the progress under treatment. With the cure of the infection the reaction becomes negative. 3. The Noguchi luetin cutaneous test for syphilis. 4. The tuberculin skin test. 5. Cutaneous tests for hypersensitivity to serum when serum treatment is indicated. 6. Allergic cutaneous tests for lesions of doubtful etiology in the genito-urinary tract. 7. The Frei test for the diagnosis of lymphogranuloma inguinale. In regard to the allergic tests, the author notes that there are several pathological conditions of the genito-urinary tract that are probably caused directly by allergic states. One of these is "giant urticaria," occurring in the pelvis of the kidneys, the ureters, and the bladder wall. Hunner's ulcer of the bladder may be an allergic phenomenon. Allergic states involving the mucous membranes—as in the gastro-intestinal and the genito-urinary tract—may not show skin manifestations and cutaneous tests may be negative. The author has used a "mucous membrane test" in cases of giant urticaria of the bladder wall in which cutaneous tests are negative. The patient's own urine is sterilized and the protein to be tested diluted with this urine, and injected into the lip. This simulates the condition in the bladder, which is "lined with mucous membrane and bathed with urine." This gives a positive reaction where cutaneous tests fail.

COMMENT

This article is informative because of the long list of seven tests which has stood for years. The borders between positive, doubtful and negative are narrow, hence the tests may be either inconclusive or misleading. In such circumstances return to clinical diagnosis may be undertaken. For example, the guinea-pig test for tuberculosis may settle the diagnosis when every other test is not satisfying.

V.C.P.

Ureteral Ectopia

H. S. EVERETT *(Southern Medical Journal, 31:843, Aug. 1938)* reports 3 cases of ureteral ectopia, one in an adult woman and 2 in children, both females. A review of the literature of the subject shows that this condition is more frequently diagnosed in females, because the ectopic ureteral orifice is often so placed that leakage of urine occurs, while in the male it is always within the external urethral sphincter, so that leakage is not a symptom. Various methods of treatment have been employed in this condition. Nephrectomy and hemine-phrectomy give good results, but when the segment of the kidney that is normally drained is normal or nearly so, nephrectomy seems to be too radical an operation. Transplantation of the aberrant ureter into the bladder has given good results in a considerable percentage of cases. Ligature and resection of the abdominal portion of the aberrant ureter was done in one of the author's 3 cases, and in 7 others reported in the literature. In the author's case the aberrant ureter was on the right side, opening into the vagina with constant leaking of urine in addition to normal periodic voiding. Intravenous urography showed the right kidney normal except for some dilation of a single calix in the upper pelvis, which was drained by the aberrant ureter. Prior to operation the normal ureter was catheterized; the aberrant ureter appeared as a "white cord" separated from the normal ureter by about 8 cm. in its abdominal portion; the abdominal segment was ligatured and resected; its lumen was found to be very small. The child made a good recovery, and is in good health; intravenous pyelograms show both renal pelves and ureters normal. All the cases treated by

this method have shown good results. It is indicated only in cases where the aberrant ureter drains a small and non-infected kidney segment.

COMMENT

Anatomical abnormalities such as ectopic ureters usually indicate surgical intervention: removal, when the ectopic is also a supernumerary ureter, or transplantation into the bladder, when it is a solitary ureter abnormally developed. The tendency of these ureters to evacuate near or into the bladder-neck is very interesting embryologically.
V.C.P.

Has Excretory Urography Displaced Retrograde Pyelography in the Diagnosis of Renal Tuberculosis?

J. L. EMMETT and W. F. BRAASCH *(Journal of Urology 40:15, July 1938)* discuss the methods of diagnosis employed in 100 cases of renal tuberculosis at the Mayo Clinic. This analysis of these cases shows that the problem in the majority of cases in renal tuberculosis is not to determine whether the infection is present, but the degree of involvement of each kidney. In 85 cases in which the urinary sediment was stained, acid-fast bacteria were demonstrated in 61 cases. In the remaining 15 cases of the series, the urinary sediment was not stained, either because the diagnosis was evident or because cystoscopic examination with staining of the ureteral urine was planned. These findings indicate that the diagnosis of renal tuberculosis can be established by history, clinical examination and staining of the voided urine in at least 70 per cent of cases. Excretory urography was done in 85 cases. On the basis of the findings 69 kidneys were classed as "good" and 95 as "bad"; 6 patients had solitary tuberculous kidney, the opposite kidney having been removed because of tuberculosis previously. Of the 69 "good" kidneys 21 were classed as normal and 25 as "probably normal," the latter showing prompt and good visualization except for the tip of a minor calix. Of these 46 normal or probably normal kidneys, 34 were catheterized and in 14 the presence of tubercle bacilli demonstrated by guinea-pig inoculation of the urine. Of the 69 kidneys classed as "good" only 7 were later examined by retrograde pyelography; in 5 of these cases this procedure gave no additional information; in 2 cases some additional information, but not necessary for diagnosis. Of the 95 cases classed as "bad" on the basis of the findings by excretory urography, 33 showed no visualization and 22 delayed visualization; dilatation of the calices was demonstrated in 36, evidence of necrosis in 20. Retrograde pyelography was done in only 11 instances in this group, and gave additional information in only 4 cases. From this analysis, the authors conclude that in most cases of renal tuberculosis, diagnosis can be established by excretory urography and examination of the catheterized ureteral specimen from the "good" kidney; repeated cystoscopic examinations are not necessary as a rule. Retrograde pyelography is, however, necessary in a small group of cases where "the disease itself is in doubt," or where the lesion is very small or circumscribed. The authors do not advise the removal of the involved kidney on the basis of the findings in the opposite kidney by excretory urography alone, without catheterization and microscopic examination of the urine from this kidney, supplemented by guinea-pig inoculation when indicated.

COMMENT

This study is very instructive and complete. When the fact of tuberculosis of the kidney is in doubt guinea-pig inoculation is still the master. When one kidney is known to be diseased its removal often or usually depends on the presence or absence of tuberculosis in the other kidney. It is very significant that the authors do not settle that point on excretory pyelography alone. Ureteral catheterization, urinalysis and the guinea pig are relied on. Conservatism and wisdom, such as these points contain, are very sure guides.
V.C.P.

+ Pediatrics +

The Significance of the Conditions of Exposure in the Study of Measles Prophylaxis

S. Karelitz *(Journal of Pediatrics, 13:195, Aug. 1938)* reports a study of

results of measles prophylaxis with placental extracts and adult immune serum in children exposed to the disease in their homes as compared with those exposed in hospitals and other institutions or by more casual contacts at schools, playgrounds, etc. In hospital ward exposures, prophylactic treatment resulted in complete protection in 85 per cent.; modification of the disease in 11 per cent.; and only 4 per cent. failures. In nurseries and in cases of exposure at school, playgrounds and in buses, etc., the degree of protection obtained was very much the same with even relatively small doses of serum. In exposure in the home where the contact with the disease is closer and more prolonged, the percentage of contacts that were protected by the serum or placental extract was definitely lower. In homes of good hygiene 54.6 per cent. of exposed children were completely protected and 7.3 per cent. developed typical measles; in homes of poor hygiene only 42.6 per cent. were completely protected and 22.6 per cent. developed typical measles. The results were best where the higher doses of serum were given, the equivalent of 10 to 30 c.c. of adult blood serum. The smaller the dose of serum injected, the greater the difference observed between homes of good and bad hygiene. This result indicates that the efficacy of measles prophylaxis depends to a considerable degree upon the nature of the exposure to the disease. With close contact and prolonged exposure, as in the home, a larger dose of prophylactic substance is required than when contact is less intimate and for shorter periods. "These observations also suggest that the nature of the spread of measles is primarily by direct contact and to some degree via the air at a relatively short distance from the source of infection."

Hepatomegaly in Juvenile Diabetes Mellitus Treated with Pancreatic Extract

H. G. Grayzal and L. S. Radwin *(American Journal of Diseases of Children, 56:22, July 1938)* note that hepatic enlargement is not a common complication of diabetes mellitus, but it occurs more frequently in diabetics in the first two decades of life than later. In most cases where this complication occurs, the size of the liver diminishes when the diabetes is controlled by diet and insulin. This is not always the case, however. The authors report 3 cases of diabetes in children in which progressive enlargement of the liver occurred in spite of dietary and insulin treatment of the diabetes, which was kept under satisfactory control for a number of years. In these cases an alcoholic extract of beef pancreas (prepared by the method of Dragstedt and his associates) was given by mouth in solution or in capsules coated with phenyl-salicylate. Aside from the hepatomegaly there was no other complication or "undesirable sequelae" of the diabetes in these patients. In all 3 cases the blood lipids were high, before beginning treatment with the pancreatic extract; they tended to become much lower under treatment with the extract. In all cases the liver decreased in size until it was no longer palpable, but to prevent a recurrence of the hepatomegaly, the administration of the pancreatic extract had to be continuous. The marked recession of the liver enlargement and the lowering of the blood lipids following administration of the extract "justify the tentative assumption" that the liver enlargement was due to fatty infiltration in these cases, and that "the therapeutic agent" in the pancreatic extract employed is a lipotropic substance. This assumption is in agreement with animal experiments and postmortem findings in human diabetics reported by others.

Relative Value of Diagnostic Procedures for the Allergic Child

A. V. Stoesser and R. E. Cutts *(Minnesota Medicine, 21:418, June 1938)* report a study of 300 cases of allergic disease in children, using various diagnostic procedures. First, the pressure-puncture cutaneous tests with glycerinized liquid extracts of the substances were used in all these cases. These tests are well tolerated by children of all ages "from infancy through puberty." In 144 of the cases, treatment based on the findings with the pressure puncture tests gave satisfactory results. The tests proved of greatest value in hay fever and bronchial asthma, and of little value

in allergic rhinitis, urticaria and gastro-intestinal allergy. Second, elimination diets were used in 147 children (excluding 9 children with hay fever). The best results, as based upon the results of treatment on the basis of the findings, were obtained in urticaria and gastro-intestinal allergy. One-third of the cases of eczema and one-fourth of the cases of allergic rhinitis were helped by the elimination diets. Finally the intracutaneous tests were used for 108 children. This method causes some pain and is often difficult to perform properly on the child. Treatment based on the findings in this group was satisfactory in 38, or 35 per cent. of the children tested. This procedure was of greatest value in allergic rhinitis. These findings indicate that the allergic child can be treated to best advantage and "with a minimum of time and effort" if it is recognized that each allergic disease has a diagnostic procedure or procedures to which it responds best. In eczema, the elimination diets and pressure-puncture tests are of greatest value; in allergic rhinitis, the intracutaneous tests; in hay fever, the pressure-puncture and intracutaneous tests; in urticaria and gastro-intestinal allergy, the elimination diets.

The Comparative Values of Various Carbohydrates Used in Infant Feeding

F. W. Schlutz and his associates at the University of Chicago *(Journal of Pediatrics, 12:716, June 1938)* report a study of the effects of various carbohydrates on the blood sugar tolerance curves of 4 children seven to fourteen years of age and 9 infants two to six months of age. The carbohydrates studied were glucose and levulose (monosaccharides); sucrose and lactose (disaccharides); and the sugar combinations —dextrimaltose, karo and honey. The blood sugar curves were determined after the administration of 2 gm. of the sugar per kg. body weight in 20 per cent solutions allowing for the water content of karo and honey. Repeated tests with different kinds of sugars were made on each individual—123 tests in all. Each individual, in general, maintained a certain type of blood sugar curve, although there was considerable difference in the rates of absorption in different individuals. Infants had a greater tolerance for glucose than older children; levulose gave somewhat similar results for both age groups. Glucose, dextrimaltose and karo gave the highest blood sugar curves; honey, sucrose, levulose and lactose were next in order. Honey appears to have special advantages for infants, because it is absorbed more rapidly than any of the other sugars tested during the first fifteen minutes except dextrose, yet it does not "flood the blood stream with exogenous sugar." It maintains a slow steady decrease in the blood sugar after the maximum level is reached. As honey is easily digested, easily available and palatable, "it would seem to be a form of carbohydrate which should have wider use in infant feeding."

Hypochromic Anemia in Infants

R. Stephenson *(American Journal of Diseases of Children, 55:1141, June 1938)* reports a study of 64 normal white American born infants from three months to two years of age, in a well conducted orphanage under good pediatric supervision. The initial hemoglobin values in these infants were "appreciably lower" than in normal adolescents and adults, as has been noted in normal infants by other investigators. Seemingly normal babies between the ages of three months and two years evidently have a borderline hypochromic anemia resulting from iron deficiency. Half of these infants were given 30 grains of iron and ammonium citrate (about 340 mg. metallic iron) daily and the other half 6 grains of ferrous sulphate (about 78 mg. metallic iron) daily. This medication was continued for three months. The optimum level of hemoglobin obtained with this treatment was 14 gm. hemoglobin per 100 c.c. blood; the hemoglobin was approximately the same in the two groups, that is, the group given the ferrous iron shared at least equally high hemoglobin as the group given ferric iron. After three months one group was withdrawn from iron therapy, while the other group continued to receive iron. The hemoglobin level tended to fall when treatment was discontinued, but rose still higher when the medication was continued. Increase in the number and

volume of red cells was also noted under iron therapy but it was less marked than the increase in hemoglobin. Improvement in the infants' color and activity under iron therapy was also noted, and increased resistance to infection was believed to result. Ferrous iron produced a "maximum effect" with much smaller doses than ferric iron and caused no gastro-intestinal disturbances. From these studies the author concludes that "Some supplemental iron appears to be needed, up to the age of two years at least, to maintain the hemoglobin at this optimal level; it is possible that less than 6 grains of ferrous sulfate would be adequate maintenance dose."

MORTALITY OF THE COLORED POPULATION FROM ACUTE RESPIRATORY INFECTION

The migration of Negroes from the rural South to the cities of the North, where they become crowded together in limited spaces that favor the spread of all sorts of infections to which they have previously built up little resistance, has resulted in many deaths. Not improbably the Negro will in time acquire a greater measure of immunity to these infections, as other races have done. In fact, there is evidence that the American Negro has developed a partial immunity to tuberculosis which renders him less apt to succumb than are colored races that have not been in frequent contact with this disease. But even if the Negro develops a degree of resistance to pulmonary infections comparable to that of the whites, he will probably continue to be handicapped by his inferior status for many years.—S. J. HOLMES, Ph.D. In *American Journal of the Medical Sciences*, April, 1938.

SOCIAL HYGIENE

Social Hygiene is a winning fight. It is a determination that two more of the diseases that afflict the social body of mankind shall be put in the process of ceasing to be formidable.

Syphilis and the gonococcal infections have ceased to be "the unmentionable diseases." They are mentionable now, hopefully mentionable, just as tuberculosis and diphtheria and yellow fever are hopefully mentionable and for the same reasons. We know what to do about them. We can get rid of them. These ancient enemies of men, these monstrous old dragons that have been so fierce and overpowering, are shrinking and cowering nowadays. Man is stronger than they.—R. L. WILBUR, M.D. In *Journal of Social Hygiene*, February, 1938.

VIRUSES AND VIRUS DISEASES

There is no adequate reason why inanimate agents cannot induce infectious diseases. Nor is it sensible to state that protozoa, fungi, bacteria, spirochetes, and rickettsiae are the only forms of living organisms capable of producing such maladies; we may be in the process of becoming aware of a new sort of living infectious agent. Thus, in regard to the nature of viruses, it seems that we are faced with three possibilities: Some of the viruses may be infinitely small living organisms, the midgets of the microbial world, possessed of a nature similar to that of living entities of sorts already known, ordinary bacteria and unicellular animals, differing from them only in respect to size; others may represent forms of life unfamiliar to us; while still others may be inanimate transmissible incitants of disease. One, two, or all three of the possibilities just mentioned may be found to hold.—T. M. RIVERS, M.D. In *Bulletin of The New York Academy of Medicine*, July, 1938.

Medical Book News

● All books for review and communications concerning Book News should be addressed to the Editor of this department, 1313 Bedford Avenue, Brooklyn, New York.

Edited by Alfred E. Shipley, M.D., Dr. P.H.

Evans' Special Study On the Eye

AN INTRODUCTION TO CLINICAL SCOTOMETRY. By John N. Evans, M.D. New Haven, Yale University Press, [c. 1938]. 266 pages, illustrated. 8vo. Cloth. $4.00.

Dr. Evans has always made thorough perimetry a part of his routine eye examinations. In addition, he has investigated the variations of the blind spot in health and disease. Finding that engorgement of the retinal vessels was associated with an immediate enlargement of the blind spot, he began a series of animal experiments to explain this phenomena. It is doubtful if anyone could foresee how soon this would lead into questions of finer retinal anatomy and lymphatic drainage, closely linked with a series of disease conditions ranging from glaucoma to choking of the disc. Non-irritating substances were injected into the vitreous and among the first results was the demonstration of the non-communication between the vitreous and the perivascular and perineural lymph spaces in the optic disc. Later the perivascular spaces of the retina were very clearly shown.

Sir George Baker
1722~1809

The book gives the results of many perimetric examinations and experiments designed to make this branch of ophthalmology more useful and better understood, together with the research work carried out. We should be grateful to the Foundation that made this publication possible, as such a specialized study would not appeal to the publisher who must depend upon quantity production to carry the burdens imposed by government taxation and the demands of labor.

RALPH I. LLOYD.

Classical Quotations

● ***Experiment is the great* basis *of our reasoning. In many cases indeed, from our very limited knowledge, we are still obliged to allow, in some degree, the doctrine of the empiric sect,* non interesse quid morbum faciat, sed quid tollat; *yet are we far from being such empirics, in the modern sense of the word, as to pay no regard to those causes, which are manifest and within our reach; such causes more especially, as lead us directly either to the cure of diseases, or, what is more desirable, to the prevention of them.***

Sir George Baker. *Med. Tr. Coll. Phy.*, London, 1772.

Anatomy of the Central Nervous System

PRACTICAL NEURO-ANATOMY. A Textbook and Guide for the Study of the Form and Structure of the Nervous System. By J. H. Globus, M.D. Baltimore, William Wood & Company, [c. 1937]. 387 pages, illustrated. 4to. Cloth, $6.00.

This well illustrated textbook for the study of the form and structure of the nervous system is designed primarily for the teaching of neuroanatomy, and accordingly many unfinished drawings, outlines, diagrams and photomicrographs have been provided. These are intended to serve the student as a guide in ac-

quiring accurate knowledge of the nervous system by requiring him to identify and label the structures correctly. Instead of the customary method of presentation by chapters, the author has subdivided the work into assignments, each assignment representing work to be accomplished during a two hour laboratory period. This book represents in miniature Doctor Globus' methods of imparting to his pupils knowledge that has been gained from many years of careful anatomical observations. It is recommended not only as an excellent text for the medical student but also as a ready source of anatomical facts for the neurologist and psychologist.

JEFFERSON BROWDER.

A Comprehensive Study of Bile

BILE, ITS TOXICITY AND RELATION TO DISEASE. By O. H. Horrall, M.D. Chicago, The University of Chicago Press, [c. 1938]. 434 pages. 8vo. Cloth, $4.00.

This is undoubtedly the most exhaustive treatise ever written on the subject of the bile, its origin, its constituents, its effects and relations in health and disease and the indications for treatment in diseases associated with abnormalities of bile secretion and excretion. It contains an exhaustive review of observations on bile and jaundice extending from the time of the ancient Egyptians to the present time. A bibliography of 2177 references and covering 123 pages includes dissertations in all languages from all over the world. Although all this sounds like dry reading, the author has taken up each subject in such a clear, logical and concise manner that it is fascinating to follow the history of the investigations in each line of work. Not only the surgeon, the internist and the research worker, but also the general practitioner will get information of value in his daily work from the many valuable suggestions as to the modern methods of prevention and treatment of the complications of jaundice and the pre- and post-operative conditions encountered in biliary tract surgery. This valuable reference book fills a long-felt want and should be in every well-balanced medical library.

A. F. R. ANDRESEN.

YOU may obtain any of the books reviewed in this department by sending your remittance of the published price to Book Department of the MEDICAL TIMES, 95 Nassau Street, New York, N. Y.

Writing for the J.A.M.A.

MEDICAL WRITING. THE TECHNIC AND THE ART. By Morris Fishbein, M.D. Chicago, American Medical Association, [c. 1938]. 212 pages, illustrated. 8vo. Cloth, $1.50.

Like some of the other great publishing houses, the Press of the American Medical Association issues its own writing code; in the case of the American Medical Association, the benefit of all concerned in the creation of the *Journal of the American Medical Association* is the objective. The present work has evolved from the old "pamphlet" known as "Suggestions to Medical Authors" and the later book titled "The Art and Practice of Medical Writing."

The aim of the present revision and extension of the old standard is the literary improvement of papers accepted for publication in the periodicals of the American Medical Association Press.

The book is admirably planned and executed. The pedagogy is painless, for much of the book makes entertaining reading.

If one expects to make one's début or reappearance in the *Journal of the American Medical Association*, one would do well to own this guide. If every aspiring author owned and assimilated it, a veritable journalistic Utopia would soon be achieved, from any editor's viewpoint. We much fear, however, to judge from the scant attention given by most authors to galley proofs, that editors will continue to do the "drudgery" for a long time to come. We should like to suggest, however, that the author who reads this book will possess a great advantage over non-readers so far as

desirable impressions made by submitted manuscripts upon the Chicago Sanhedrin are concerned. *Verbum sap.*

The *Journal of the American Medical Association* is itself the impeccable result of its own self-created code, and the profession is justly proud of it.

ARTHUR C. JACOBSON.

Sexual Problems of Women

LOVE AND HAPPINESS. Intimate Problems of the Modern Woman. By I. M. Hotep, M.D. With a prefatory note by Dr. Logan Clendening. New York, Alfred A. Knopf, [c. 1938]. 235 pages. 12mo. Cloth, $2.00.

This volume is addressed particularly to women. The author, from a broad humanistic viewpoint, explains many of the problems of sex as they relate to women's love and happiness.

The author groups women into five classes or age groups, and discusses clearly and plainly the sex problems affecting women in these divisions.

The book is written in an easy readable style, and covers and explains many subjects which are not stressed in the ordinary volume on sex.

Most women, young or old, will find this book of value in helping them to solve many a difficult problem of love and happiness.

WILLIAM SIDNEY SMITH.

The Diet Factor in Health

EAT AND KEEP FIT. By Jacob Buckstein, M.D. New York, Emerson Books, [c. 1938]. 128 pages. 8vo. Cloth, $1.00.

This is another book for the hungry public. The jacket tells that the volume contains "scientific secrets of diet" and "new and improved fourteen day diets."

The subject matter discusses the present day concept of proteins, protective foods, minerals and vitamins.

The reader is requested to see his own physician before trying to lose weight; however, the extra expense of an office visit would not seem necessary when a complete menu for each of the fourteen days is given in full by Dr. Buckstein.

The fourteen day diet has balanced menus, contains sufficient protective foods and the two glasses of milk each day, and thus meets all the nutritional requirements of a good diet.

As a general principle the book is not recommended to the public. Diet instruction must be individual, and must be prescribed by the patient's own physician.

PAUL C. ESCHWEILER.

Legal Nursing Problems

JURISPRUDENCE FOR NURSES. Legal Knowledge Bearing Upon Acts and Relationships Involved in the Practice of Nursing. By Carl Scheffel, M.D. Second edition. New York, The Trained Nurse and Hospital Review, [c. 1938]. 248 pages. 8vo. Cloth.

Dr. Scheffel has rearranged and completely rewritten his first edition thus presenting a modern up to date reference for nurses.

In this enlarged revision the collaboration of Eleanor McGarvah, R. N., also a member of the Michigan Bar, is ably reflected throughout the text.

Substantive as well as Adjective law (as it concerns the nurse), with a quiz at the end of each chapter, exemplifies the thoroughness on the part of the author. Especially enlightening are the chapters on Wills and Property Rights.

Legal nursing problems, vivid with its colorful citations; a study of registration laws of the various states render the book complete in every phase. The general style of presentation is clear, terse and factual as only medico-legal experience can offer.

The reviewer feels that a nurse devoid of this information is like an unchartered ship.

S. INGRAM HYRKIN.

Factual Basis of X-Ray Therapy

THEORETICAL PRINCIPLES OF ROENTGEN THERAPY. Edited by Ernst A. Pohle, M.D. Philadelphia, Lea & Febiger, [c. 1938]. 271 pages, illustrated. 8vo. Cloth, $4.50.

Dr. W. E. Chamberlain's foreword to this small volume accurately describes it as containing the factual basis of Roentgen therapy.

In this one volume the roentgenologist will find concisely stated the basic physical and practical knowledge necessary in the practice of Roentgen therapy. Each contribution to this book is so complete as to be of value as a reference to physicist as well as therapist. The bibliography is satisfactory in that it details articles of present interest, and excludes all those which are of historical value only.

This book deserves a place in every radiological library.

A. L. L. BELL.

New Editions of Standard State Board Manuals

MEDICAL STATE BOARD EXAMINATIONS. Topical Summaries and Answers. An Organized Review of Actual Questions Given in Medical Licensing Examinations Throughout the United States. By Harold Rypins, M.D. Third edition, revised. Philadelphia, J. B. Lippincott Company, [c. 1937]. 448 pages. 8vo. Cloth, $4.50.

MEDICAL STATE BOARD QUESTIONS AND ANSWERS. By R. Max Goepp, M.D. Seventh edition. Philadelphia, W. B. Saunders Company, [c. 1938]. 644 pages. 8vo. Cloth, $5.50.

Both of these books have passed through several editions, all of which have been popular, and both have been thoroughly revised and brought up to date. Both are clear, concise and accurate. Dr. Rypins, as always, writes with distinction, and the personal foreword should be read carefully by every student or graduate who is preparing to take any kind of medical examination. It gives sound practical advice. Goepp has the merit of including more material, all of it well arranged. It is full enough, indeed, to be used in reviewing for state, national, and special board examinations. Both books can be highly recommended.

MILTON PLOTZ.

Mackee's Radiological Dermatology

X-RAYS AND RADIUM IN THE TREATMENT OF DISEASES OF THE SKIN. By George M. MacKee, M.D. Third edition, thoroughly revised. Philadelphia, Lea & Febiger, [c. 1938]. 830 pages, illustrated. 8vo. Cloth, $10.00.

The third edition of this book is changed considerably from the last which came out about ten years ago. It does not even resemble the first edition which made its appearance in 1921, the changes have been so extensive.

Dr. MacKee has had the advantage of nine collaborators, who are outstanding authorities in their respective fields, to revise many of the chapters and bring them up to date according to present-day knowledge and experience. By so doing he has eliminated from the first two editions a great deal of obsolete material.

The first half of the book is given over to the historical, physical, biological, biochemical, etc., phases of roentgen and radiumemanation. All the various and sundry considerations involved in the use of these two agents are discussed and treated in great detail. He leaves nothing to be desired.

The second half of the book is devoted to general therapeutic considerations. Wherever possible, the author classifies the diseases under consideration according to the system involved or according to the etiologic factor involved. Then again, where the pathology lends a helping hand he readily classifies the new growths according to their malignancy or non-malignancy. Where neither of the above bases works out, he discusses certain diseases individually, such as eczema, to which he devotes an entire chapter.

The bibliography in this edition serves as an index to progress made. Taking several chapters at random and comparing them with corresponding chapters in the first editions, we find the references more than doubled. This is an excellent guide to the up-to-dateness of the text.

All in all, it is an excellent book. It is replete with illustrations, and should be in the library of every person who does this type of radiological work.

GEORGE F. PRICE.

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Biochemistry Practically Applied

CLINICAL CHEMISTRY IN PRACTICAL MEDICINE. By C. P. Stewart, Ph.D. and D. M. Dunlop, M.D. Second edition. Baltimore, William Wood & Company, [c. 1937]. 372 pages, illustrated. 16mo. Cloth, $4.00.

This book is designed both for the student of medicine receiving clinical instruction in the later years of his course, and for the physician who has not received special instruction in the medical applications of biochemistry. It is free from the objectionable restrictions and divisions that limit the utility, for advanced workers, of manuals written solely for student courses. The material covered is so treated that it is especially useful to those interested in clinical laboratory procedures and their interpretations.

The second edition has been thoroughly revised and brought up to date in accordance with the concepts of the best authors in both biochemistry and clinical medicine.

MATTHEW STEEL.

The Individual and His Environment

PERSONALITY AND THE CULTURAL PATTERN. By James S. Plant, M. D. New York, The Commonwealth Fund, [c. 1937]. 432 pages. 8vo. Cloth, $2.50.

This book is rather unusual, both in its formal and intrinsic aspects. It represents a continuity of fluid thoughts which the author has developed out of his experience in a child guidance clinic. Externally, these ideas seem to have as little finish as homespun (because the author is impatient with style for its own sake and because he hasn't had the opportunity of developing a style adequate to express his imperfectly consolidated ideas). But they have all the attractiveness and strength of the handwoven material.

Plant finds the emotional problems of children (and adults) today to be in large measure the resultant of modern social forces expressing themselves in the warping of personalities just as they manifest themselves in the upheaval of community life, industrial maladjustments, etc. But his is not the finger-pointing or moralistic blaming. He analyzes the characteristics of today's family life, schools, cities and work conditions in their detailed emotional effects in the individual, and evolves a type of psychiatric thinking which is quite different from the highly individualistic thought of dynamic psychology, for example.

It is impossible competently to reflect the scope of Plant's thought in the confines of this review beyond recommending the book as one of the most substantial medical productions of recent times. It is also a stirring social document which places psychiatry at the forefront of social adaptation.

SAM PARKER.

A Study on the Education of the Interne

INTERNSHIPS AND RESIDENCIES IN NEW YORK CITY, 1934-1937. Their Place in Medical Education. Report by the New York Committee on the Study of Hospital Internships and Residencies. Jean A. Curran, M.D., Executive Secretary. New York, The Commonwealth Fund, [c. 1938]. 492 pages. 8vo. Cloth, $2.50.

This is a volume that should be in the hands of every hospital executive, trustee, attending and medical educator. It is fascinating reading and contains a wealth of useful information, challenging ideas and practical suggestions. It portrays the internship and residency as part of the continuous educational process of the competent physician and shows that this conception is but dimly recognized in many of our New York hospitals. There has been a tendency to look upon the young graduate as a doctor fully trained to carry on the work of the hospital. Many interesting observations are made upon the internship as preparation for practice. Judged by their later careers too many internes receive training in major surgical techniques and all receive too little training in the handling of problems of the sort to be encountered in the home. Many hospitals fall down in their training of new internes for their hospital duties. In many the case load per interne is too heavy, resulting in short cuts to save time and finally lowered standards of excellence. Record keeping could be greatly improved in many instances. Although many faults were found in the internships and residencies offered in New York, Dr. Curran and the Committee were quick to point out that there is much that is of a very high order and that hospital executives and attending staffs are already awake to the great possibilities that lie in the better coordination of the medical school course, internship and residency into a continuous educational process.

This volume is truly inspiring and will be quickly recognized as a very important contribution to the field of medical education.

EDWIN P. MAYNARD, JR.

Brill's Re-Translation of Jung's Dementia

THE PSYCHOLOGY OF DEMENTIA PRAECOX. By Dr. C. G. Jung. (Nervous and Mental Disease Monograph Series No. 3). Authorized translation with an introduction by A. A. Brill, M.D. Washington, Nervous and Mental Disease Publishing Company, [c. 1936]. 150 pages. 8vo. Paper, $2.50.

This monograph made its appearance originally in 1906, the English translation being made by Dr. A. A. Brill, who was associated at the time with Jung in Zurich. The first American edition was small and was soon exhausted, but no second edition was published at the time. As a result of many requests both to the author and to the publishers for a

second edition, Dr. Brill has entirely retranslated the original brochure, which, in its new form, made its appearance in 1936 as one of the series of monographs produced by the Nervous and Mental Diseases Publishing Company.

The first chapter deals with the psychology of dementia praecox, the second and third treat of the relationship of the emotional complexes to the general psyche and to association. The fourth chapter considers the relation of dementia praecox with hysteria, while the final section is devoted to the detailed analysis of a case of paranoid dementia.

F. C. EASTMAN.

Helmholtz on Medical Thought

ON THOUGHT IN MEDICINE. By Hermann von Helmholtz. An Address delivered August 2, 1877 on the Anniversary of the Foundation of the Institute for the Education of Army Surgeons. Baltimore, The Johns Hopkins Press, [c. 1938]. 27 pages. 4to. Paper, $.75.

This volume is a translation of a lecture delivered by Helmholtz on the anniversary of the foundation of the Institute for the Education of Army Surgeons. It is an answer to his contemporaries, who wanted to scrap the method of natural science for a mess of metaphysics. Although the lecture was delivered in 1877 it is entirely modern in tone, and will undoubtedly be of interest to many physicians. It is a worthy edition to the series of medical texts and documents which have appeared in the *Bulletin of the Institute of the History of Medicine.*

GEORGE ROSEN.

Health of Mid-Life

MIDDLE AGE IS WHAT YOU MAKE IT. By Boris Sokoloff, M.D. New York, The Greystone Press, [c. 1938]. 204 pages. 8vo. Cloth, $1.75.

The spirit and purpose of the book can be best conveyed by the following paragraph from the Foreword:

The man approaching middle age is somehow a step-son of medical science. We physicians are ready to admit this, with a certain amount of bitterness. While the hygiene, diet and diseases of infants and children have been the objects of remarkable achievement, the man in his early forties has been virtually left to his own care, because of his apparent self-sufficiency. Believing that he is perfectly healthy, he pays no attention to minor ailments. The results are obvious.

It advocates the establishment of a philosophy of life suitable to each individual, and one which aids in meeting the difficulties and disappointments and quickly restoring mental and physical balance.

Throughout, the book is a storehouse of authoritative information presented in a most readable style.

It would be of great advantage to every man and woman to read this book from cover to cover. It receives the reviewer's most enthusiastic approval.

S. R. BLATTEIS.

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A German Symposium on Cancer

NEUERE ERGEBNISSE AUF DEM GEBIETE DER KREBSKRANKHEITEN. 47 Vorträge gehalten mit Unterstützung des Reichsausschusses für Krebsbekämpfung in einem internationalen Fortbildungskurs der Berliner Akademie für ärztliche Fortbildung. Leipzig, S. Hirzel, [c. 1937]. 366 pages, illustrated. 4to. Paper, RM. 12.

This book consists of 47 theses on various cancer problems by as many collaborators of recognized reputation throughout the German Reich. It is really a symposium which represents the best thought on the subject in modern German medicine. It is a very able, up-to-date review of the whole field of cancer; including discussions on predisposition, heredity, biology, etiology, research on artificial cancer production, prophylaxis, x-ray and radium therapy and operative procedure. To readers of German, the book is a gold mine, containing much demonstrated fact and abundant food for thought and discussion. One cannot read the book without acquiring fundamental knowledge and a broader conception of one of the major disasters in modern medicine. While there are many moot points, these are presented in a manner to whet appetite for further research. The book reveals an enormous amount of work, typically German in thoroughness.

J. M. VAN COTT.

Pathology for the Gynecologist

ESSENTIALS OF OBSTETRICAL AND GYNECOLOGICAL PATHOLOGY WITH CLINICAL CORRELATION. By Marion Douglass, M.D., and Robert L. Faulkner, M.D. St. Louis, The C. V. Mosby Company, [c. 1938]. 187 pages, illustrated. 4to. Cloth, $4.75.

This short volume presents most concisely the clinical symptoms, gross and microscopic findings in the common diseases of the female generative tract. An excellent histological and embryological review precedes clinical and pathological presentation.

The several chapters are devoted to a study of degenerative, inflammatory and neoplastic lesions involving vagina, uterus, tubes and ovaries. Although the text is somewhat brief it is sufficient for the undergraduate student for whom this work is particularly indicated. The microphotography is well executed and the legends help to carry the story. Ovarian neoplasms are completely illustrated, and the most recent classification presented. Granulosa cell tumors, dysgerminomas and Brenner tumors are all described.

Under obstetrical pathology there is an excellent review of early and late changes of pregnancy. Abnormalities of placenta including chorionic carcinoma are well covered. Printing and format leave nothing to be desired.

In brief this short volume is a most valuable presentation for the undergraduate and graduate student to whom gynecological micropathology is especially important.

SAMUEL A. WOLFE.

A Revision of Bell's Pathology

A TEXT-BOOK OF PATHOLOGY. Edited by E. T. Bell, M.D. Third edition, enlarged and thoroughly revised. Philadelphia, Lea & Febiger, [c. 1938]. 894 pages, illustrated, 8vo. Cloth, $9.50.

The University of Minnesota Department of Pathology has further enlarged its student text with the present revision. Cooperatively arranged through the collaboration of five members of the medical faculty, the result is an up-to-date authoritative volume that brings the essentials of pathology in close relation to clinical medicine. Especially marked in value for instructive purposes are the illustrations, original throughout, excellently printed, and nicely selected for clinical stress. Also valuable for pathologic orientation during clinical training are the specific references noted at the end of each subject. The chapter divisions of Special Pathology are well adapted to the use of the student throughout his collegiate courses. Noteworthy are those of Gynecological Pathology, Neuropathology, Diseases of the Urinary System, of the Blood, and of the Bones and Joints. The book is recommended not alone for student use, but may well provide the practitioner with pathologic essentials in specialized fields.

IRVING M. DERBY.

Racial Characteristics and Mentality

THE MIND OF PRIMITIVE MAN. By Franz Boas. Revised edition. New York, The Macmillan Company, [c. 1938]. 285 pages. 8vo. Cloth, $2.75.

The present revision of this authoritative book appears after a lapse of many years. In the interim, important progress made in the field of heredity and the influence of environment upon bodily form and behavior has necessitated a revision of much of the material contained in the first edition.

In common with many others, the author is vehement in his denunciation of those countries controlled by dictators where science is subjugated to racial prejudices. As a result of his investigations he finds it difficult to agree with those who attempt to show the supremacy of one race over another by pseudo-scientific facts. Some of the facts set forth, especially in regard to the primitive mind of the Negro, may not be in accord with our usual concept of the Negro mind.

The style is very readable and the book will be of interest to the layman as a source of general information as well as to the scientist who seeks cold facts.

JOSEPH L. ABRAMSON.

BOOKS RECEIVED

for review are promptly acknowledged in this column; we assume no other obligation in return for the courtesy of those sending us the same. In most cases, review notes will be promptly published shortly after acknowledgment of receipt has been made in this column.

A TEXTBOOK OF GYNECOLOGY. By Arthur Hale Curtis, M.D. Third edition. Philadelphia, W. B. Saunders Company, [c. 1938]. 603 pages, illustrated. 8vo. Cloth, $7.00.

DISEASES OF THE SKIN FOR PRACTITIONERS AND STUDENTS. By George C. Andrews, M.D. Second edition. Philadelphia, W. B. Saunders Company, [c. 1938]. 899 pages, illustrated. 8vo. Cloth, $10.00.

THE AMERICAN ILLUSTRATED MEDICAL DICTIONARY. By W. A. Newman Dorland, M.D. Eighteenth edition. Philadelphia, W. B. Saunders Company, [c. 1938]. 1607 pages, illustrated. 8vo. Cloth, $7.50 with thumb index.

A TEXTBOOK OF BACTERIOLOGY. By Thurman B. Rice, M.D. Second edition. Philadelphia, W. B. Saunders Company, [c. 1938]. 563 pages, illustrated. 8vo. Cloth, $5.00.

VITAMIN B_1 (THIAMIN) AND ITS USE IN MEDICINE. By Robert R. Williams, Sc.D., and Tom D. Spies, M.D. New York, The Macmillan Company, [c. 1938]. 411 pages. 8vo. Cloth, $5.00.

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